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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2232-F2
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-2232-F2 (Medicaid benchmark regulations)

Dear Ms. Gerhardt:

The National Health Law Program is a public interest law firm working to maintain and improve access to quality health care for low-income people, children, people with disabilities, and people of color. We provide legal analysis and representation, education, and policy advocacy. With offices in California, North Carolina, and Washington, DC, NHeLP provides specialized assistance on public health insurance matters to attorneys, community-based organizations, state and national policy makers, and parents and program beneficiaries. We are writing to comment on regulations addressing State Flexibility for Medicaid Benefit Packages, which currently have a delayed effective date of December 31, 2009.

We ask that these regulations be permanently withdrawn and new regulations be issued, for the following reasons:

- 1. The regulations are inconsistent with CHIPRA's unambiguous congressional intent restoring the centrality of EPSDT for Medicaid-eligible children and youth.**

With CHIPRA, Congress makes it clear that it still considers the Early and Periodic Screening, Diagnostic and Treatment service (EPSDT) a primary component of the Medicaid program—not surprising given the numbers of children and youth who depend on Medicaid to meet their disproportionate needs for health and assistance services. CHIPRA clarifies that states must “provide EPSDT services for all children in benchmark benefit packages under Medicaid.” See CHIPRA, § 611(a).

The Deficit Reduction Act of 2005 (DRA) benchmark provision improperly excluded children aged 19-21 from the protection of the

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EPSDT provisions. CHIPRA corrects this error by requiring state benchmark programs to cover Medicaid-eligible individuals under age 21.

CHIPRA also revises the law to ensure that children under age 21 actually receive EPSDT. Specifically, CHIPRA removes the word “wraparound” from the benchmark option. This means that EPSDT must be restored as the central, critical service for children and youth under age 21, whether or not they are enrolled in a benchmark plan. In other words, EPSDT cannot be a one-line promise by states in their state plan requests; rather, the regulations should require that state plan proposals fully explain how EPSDT will be maintained and place states on notice of how their programs will be monitored to ensure that children’s access to EPSDT is being maintained and *improved* under the benchmarks.

The CHIPRA change also signals that Congress intends that beneficiaries and their families actually understand the EPSDT program and service options and that the program is fully available to them. To this end, the benchmark regulations must require states offering benchmark options to assure effective and actual access to the full range of EPSDT, not through confusing “wraparound” options. This means: (1) timely and effective informing of families and youth about EPSDT, (2) periodic and interperiodic medical, vision, hearing and dental screening, (3) comprehensive treatment (as described in 42 U.S.C. § 1396d(a) when needed by the individual child to correct or ameliorate a physical or mental condition), and (4) reporting to allow timely and accurate completion of the CMS Form-416. See CHIPRA 611(a) (amending 42 U.S.C. § 1396u-7(a)(1)(A)(ii) and citing 42 U.S.C. §§ 1396d(a)(4)(B), a(a)(10), a(a)(17), a(a)(43), d(r)).

Accordingly, as currently written, 42 C.F.R. § 440.345 is inconsistent with CHIPRA and must be withdrawn.

2. The regulations are inconsistent with CHIPRA’s unambiguous provisions allowing only select Medicaid provisions to be ignored in benchmark programs.

The DRA appeared to allow states to ignore any provision of title XIX when exercising the benchmark option. CHIPRA corrects this misimpression by amending the Medicaid Act to list the specific Medicaid provisions that can be disregarded in state plans using benchmark coverage. *Compare* previous 42 U.S.C. § 1396u-7(a)(1)(A) (“Notwithstanding any other provision of this subchapter...”) *with* CHIPRA § 611(a) (amending § 1396u-7 to state: “Notwithstanding [§ 1396a(a)(1)] (requiring statewideness), [§ 1396a(a)(10)(B)] (requiring comparability) and any other provision of this title which would be *directly contrary* to the authority under this section...”) (Emphasis added). The amended statute allows states to ignore only a few specified Medicaid provisions. Other than a direct conflict with 42 U.S.C. § 1396a(a)(23)(A), the “freedom of choice” provision, in those states requiring enrollment in a managed care entity, our review of title XIX revealed no other provision that, on its face, would be “directly contrary” to the benchmark option. When CMS re-writes and re-promulgates

the benchmark regulations, we urge the agency to establish a presumption that will allow states to ignore only statewideness; comparability; and, when appropriate, freedom of choice.

As examples of required provisions: (1) CHIPRA includes a number of quality of care and health outcome measures that will be undermined if they are not incorporated into benchmark options. In fact, because these measures are not directly contrary to the benchmark option, they must be incorporated into any benchmark plan. For example, a benchmark state must assure that “no evidence based quality measure developed, published, or used as a basis of measurement or reporting under CHIPRA 401(b) may be used to establish an irrebuttable presumption regarding either the medical necessity of care or the maximum permissible coverage for any individual child who is eligible for and receiving medical assistance” under Medicaid or CHIP. See CHIPRA § 401(b). (2) The Due Process Clause of the US Constitution requires individuals to receive adequate notice and an opportunity for a fair hearing whenever their claims are denied, reduced, terminated, or not acted on with reasonable promptness. See *Goldberg v. Kelly*, 397 U.S. 254 (1970); 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.200 et seq. (expressly implementing *Goldberg*). All benchmark-participating plans must meet these individualized notice and fair hearing requirements.

3. The regulations are inconsistent with CHIPRA’s modifications of the Secretary-approved benchmark coverage option.

The previous Administration has approved most states’ benchmark requests through the standardless “Secretary-approved” benchmark option. See 42 U.S.C. § 1396u-7(b). The states worked with the Bush Administration to implement the coverage and, as applied, it was not at all clear what criteria the Secretary used to approve the state plans. The CHIPRA amendments order a halt to this practice. Because the current regulations do not incorporate the CHIPRA changes, they must be withdrawn.

CHIPRA provides that on the date a state plan amendment is approved, the DHHS Secretary must publish on the CMS website a list of the Medicaid provisions that the Secretary has determined do not apply in order to enable the state to carry out the plan amendment and the reasons for each such determination. (As noted above, the Secretary should allow states to ignore only a few, specified Medicaid provisions.) This authority needs to be implemented in regulation, and it needs to be coordinated with the current requirement, which should be maintained, that states must secure public input prior to the submission of any state plan amendment to CMS. See current 42 C.F.R. 440.305(d). The revised regulations should inform states that they must list the specific Medicaid Act provisions they seek to ignore, obtain public input regarding this planned action, and that CMS will consider allowing the state to ignore only those provisions that have been subjected to public input. Moreover, with respect to public input, CMS should use re-promulgation as an opportunity to advance President Obama’s encouragement of government transparency by establishing minimum standards for assuring meaningful public input as states are developing their plans.

The benchmark regulations need to be revised to incorporate standards for the Secretary-approved benchmark. The West Virginia Secretary-approved benchmark plan, Mountain Health Choices, illustrates why standards are badly needed. Our office is involved in ongoing litigation, *D.W. v. Walker*, on behalf of children who are being harmed by the approval of the benchmark plan. Under this plan, children are enrolled in a “basic” health plan, unless their parents sign and adhere to a patient responsibility agreement. Parents who meet the agreement gain access to an “enhanced” benefit plan for their children. The basic plan for children contains a number of benefit exclusions and quantitative or monetary caps on benefits, including:

- Weight management – not covered
- Nutrition education services – not covered
- Private duty nursing services – not covered
- Inpatient hospital psychiatric services -- 30 days/year
- Prescription drugs – 4/month
- Speech and related therapies – 20/year(for all therapies combined)
- Vision services – maximum of \$750/year
- Chemical dependency/mental health services – 25/year.

Our own investigations and recent reports have shown that parents, providers, and community groups are confused by the new plan. Children are going without necessary care and services. For example, D.W. is in the basic health plan. He has been diagnosed with several learning disabilities. As alleged in our complaint, he was experiencing difficulty in school beyond explanation of these disabilities. Ultimately, D.W. was diagnosed with a hearing impairment. He sought treatment from a hearing specialist pursuant to a referral from his treating physician but could not get the treatment because he was told it is not covered by the basic plan. D.W. also sought treatment from a certified mental health counselor but could not get it. (D.W. received no written notices of the denied coverage.) As of December 2008, approximately 85 percent of those enrolled in Mountain Health Choices are children, and approximately 93 percent of children are enrolled in the basic plan. Despite the longer implementation time in the three start-up counties (Clay, Upshur, Lincoln), 85 percent of the children in these counties are in the basic plan. This is unacceptable, and the current regulations—which are written to perpetuate and repeat these circumstances—should be withdrawn.

4. The regulations need to be revised to include family planning and necessary transportation as mandatory services for adults and children in benchmark plans.

The current regulations do not clearly require benchmark plans to include the full range of family planning services and supplies for both EPSDT-eligible youth and covered adult populations. The CHIPRA revisions limit states' ability to ignore Medicaid provisions. The Secretary should not allow states to ignore 42 U.S.C. § 1396d(a)(4)(C), listing family planning services and supplies as a mandatory Medicaid service, and 42 U.S.C. § 1396a(a)(23)(B), requiring managed care entities to maintain freedom of choice of family planning service provider. These provisions are necessary so that

Medicaid can be operated in the best interests of the beneficiaries, as required by 42 U.S.C. § 1396a(a)(19)—a Medicaid provision that clearly cannot be ignored in a benchmark program.

The current regulations also omit the assurance of necessary transportation services for individuals in benchmark plans. We strongly disagree with the reasoning of the previous administration that excused benchmark plans from assuring necessary transportation, 73 Fed. Reg. 73,714-19. We urge CMS to reverse the policy. Adults, children and youth qualify for Medicaid because they are unable to afford life's basic daily necessities and health care. Enrollment of an individual into a benchmark plan does not change this. Thus, CMS should find that 42 U.S.C. § 1396a(a)(19) and § 1396a(a)(4) continue to require assurance of necessary transportation in all states, including those using benchmark plans. Moreover, as a matter of law, the CHIPRA change to § 1396u-7 means that § 1396a(a)(4) cannot be ignored because it is not “directly contrary” to the benchmark option. Thus, the transportation requirement implemented pursuant to that statute, 42 C.F.R. § 431.53, must remain in full force and effect and cannot be ignored in benchmark states.

5. The regulations need to be withdrawn so that provisions for exempting populations and covering benefits are consistent with the Americans with Disabilities Act (ADA).

The Department of Health and Human Services is a federal agency charged with guiding and monitoring ADA implementation. As services, programs or activities of a public entity, state Medicaid programs must adhere to the requirements of the ADA. 42 U.S.C. § 12132.

The current regulations rejected suggestions for assuring adequate coverage of mental health services and services for beneficiaries with life-threatening conditions such as AIDS/HIV. The federal agency refused to alter the regulations and told these commenters to take their concerns to the states. See, e.g., 73 Fed. Reg. 73,698-99. With this response, the federal agency failed its responsibility to implement and enforce the ADA. The current benchmark regulations should be withdrawn and revised to include requirements for benchmark plans to maintain and improve access to mental health services and services for beneficiaries with life-threatening conditions. Moreover, the regulations should include requirements for benchmark plans to make reasonable accommodations (e.g. medically appropriate transportation, person-centered home care services) for those enrollees who are qualified individuals with disabilities.

In addition, “medically frail” populations are exempted from mandatory enrollment. However, the definition of “medically frail” that is incorporated into the current regulations is insufficient. The regulations do incorporate some exemptions from the managed care regulations (42 C.F.R. § 438.50(d)(1) and (3)) for beneficiaries who are also eligible for Medicare and certain children under age 19 (e.g. foster care, SSI-eligible)). Otherwise, states are given the option to decide who else may qualify as medically frail. To begin with, reliance on the managed care regulations is insufficient

because the enrollment processes produce very different results. The managed care enrollees covered by 42 C.F.R. § 438 remain entitled to the full range of Medicaid benefits and services. By contrast, benchmark enrollees are enrolled in commercial or Secretary-approved plans that do not operate according to traditional Medicaid provisions that are specifically designed to meet the health and access needs of low-income people. Moreover, the ADA is a *federal* law that establishes federal standards and protections for people with disabilities, who broadly include medically frail individuals. It is inconsistent with the ADA to allow the definition of medically frail to vary from state-to-state. For example, it would be harmful for any person who is bipolar, but not medically frail as currently defined, to have to enroll in a benchmark that limits mental health and psychiatric care. The definition should be revised to set a national floor for the definition, to include individuals with multiple medical conditions and/or chronic illness.

6. CMS should withdraw the regulations and correct “opt out” provisions that are confusing and unfair to exempt population groups.

As enacted, the benchmark statute exempts many populations from mandatory enrollment in benchmark plans. The current regulations allow states to enroll exempt individuals on a voluntary basis. See 42 C.F.R. §§ 440.305, 440.320. NHeLP strongly objects to the notion of “voluntary” enrollment that the current regulations appear to sanction. Specifically, state benchmark programs should not be allowed to use “opt out” enrollment whereby exempt population groups are enrolled in a benchmark plan and *then* informed that enrollment is voluntary and they can get out of the plan at any time if they want. Rather, the states should be required to provide full, understandable and individualized information to exempt populations who, *after that*, can choose whether to enroll and to get out of the plan at any time if they want. That is the common sense concept of *voluntary* enrollment. Moreover, Congress exempted populations from mandatory enrollment for a reason—they have ongoing and immediate health care needs or have historically encountered barriers to care. The opt-out concept described above is entirely inconsistent with congressional intent. Moreover, many states have poor track records of adequately informing individuals about the health care options.

7. CMS must withdraw the regulation because its listing of exempt populations is inconsistent with the Medicaid Act.

In the DRA, Congress listed “TANF and section 1396u-1 parents” as populations excluded from mandatory enrollment. However, the text of the exclusion only describes individuals “who qualify for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect *on or after* the welfare reform effective date ... [July 16, 1996].” DRA, § 6044 (Emphasis added). After July 16, 1996, AFDC was replaced by TANF in title IV-A, and there is no automatic qualification for Medicaid on the basis of title IV-A eligibility. *Cf.* 42 U.S.C. § 1396u-1 (treating individuals as automatically eligible for Medicaid if they meet the IV –A requirements *in effect as of* July 16, 1996). Thus, the statute could be read to create a null set and to allow states to mandatorily enroll individuals eligible under section 1396-

1. From the title of the provision, however, it is clear that Congress intended to exempt both TANF parents and parents eligible through 42 U.S.C. § 1396u-1. The current regulation parrots the statutory language and, thus, is inadequate.

CMS also needs to withdraw the regulation so that it can consider how states should apply the benchmark option to American Indian/Alaska Native (AI/AN) populations. Previous comments have described the problems with requiring AI/AN populations to enroll in benchmark plans. See, e.g., 73 Fed. Reg. 73,700-02. While Congress did not exempt AI/AN populations from benchmark enrollment, CHIPRA amended the benchmark provision to narrow the Medicaid provisions that states can ignore. Because 42 U.S.C §§ 1396a(a)(4) and 1396a(a)(19) are not directly contrary to the benchmark provision, they cannot be ignored, and these provisions authorize CMS to implement policies to assure effective operation of Medicaid in the best interests of recipients, in this case AI/AN populations. Importantly, the American Recovery and Reinvestment Act (ARRA), § 5006, established new protections for Indians who receive Medicaid and CHIP services to, among other things, improve timely access to care and provider choice. These later-enacted provisions must be considered when promulgating benchmark regulations. Moreover, ARRA requires the Secretary of DHHS to establish and maintain a Tribal Technical Advisory Group (TTAG) within CMS. See ARRA, § 5600(e)(1). The regulations should be revised in consultation with the TTAG.

8. The regulations should be withdrawn and revised in conjunction with the re-promulgation of the cost sharing regulations.

CMS is concurrently reviewing the Premiums and Cost Sharing Final Rule, 73 Fed. Reg. 71, 828. The benchmark regulations should be withdrawn so that the two regulations can be considered and revised in tandem. Decisions regarding cost sharing and premium requirements will affect benchmark provisions on a range of issues, from actuarial soundness to voluntary enrollment.

Conclusion

We strongly urge CMS to permanently withdraw the current benchmark regulations and to rewrite and promulgate them so that they are consistent with CHIPRA, ARRA, EPSDT, and the ADA. We appreciate your consideration of these comments. If you have questions, please contact Jane Perkins at (919) 968-6308.

Sincerely,

National Health Law Program

By: /s/Jane Perkins
Jane Perkins
Legal Director