October 19, 2001

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2104-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-2104-P
Medicaid Managed Care; Proposed Rule

Dear Sir or Madam:

The National Health Law Program is a private, non-profit organization which advocates on behalf of low-income individuals to access health care. We submit these comments on the Notice of Proposed Rulemaking regarding the Medicaid managed care program on behalf of the undersigned organizations.

The Delay of the Final Rules

On January 19, 2001, the Centers for Medicare and Medicaid Services (CMS) issued final regulations implementing the Balanced Budget Act of 1997 Medicaid managed care provisions. 66 Fed. Reg. 6228 (Jan. 19, 2001). These regulations were to go into effect on April 19, 2001. However, CMS delayed implementation of the final rules three times, delaying the effective date with the last notice until August 16, 2002.

CMS' notice of "further delay of effective date" issued in August, and the previous delays, violate the Administrative Procedures Act because they changed the effective date of the January final regulations without first allowing for required notice and comment. In addition, CMS neither claimed, nor would it be able to demonstrate, that the rule meets any of the exceptions allowing CMS to bypass the prior notice and comment requirements. We request that the January regulations be implemented immediately.

Informing

The proposed rule omits any requirement on health plans to provide information to enrollees about services that the health plans refuse to provide based on moral or religious grounds. Proposed §§ 438.10(e)(2)(ii)(E), (f)(6)(xii). This omission eliminates an important mechanism for women to receive information when it is most relevant - at the point of service. Allowing health plans not to

provide covered services to which they object on moral or religious grounds is already a significant accommodation for any entity - that is all that is required under our Constitution for entities that wish to participate in a public program and to receive our taxpayer dollars which are meant to be spent to ensure health care access to a defined scope of services. The Constitution does not require lifting the obligation on plans to provide this information. Health care access should be made equally available to men and women. By omitting the requirement to provide information, CMS encourages and permits discrimination against women, ignores their health care needs, and discounts the religious and moral beliefs of Medicaid beneficiaries.

We strongly urge at the least that health plans be required to provide a referral to a state-sponsored toll-free number that informs beneficiaries about how and where to access services that the health plan does not provide. Health plans also should inform beneficiaries about the fact that the services are not available within the health plan but are otherwise covered under Medicaid. All of this information should be provided at the point of service and annually. Entities not willing to provide this information could choose not to participate in Medicaid. In addition, each State which contracts with such entities should maintain this toll free number to inform beneficiaries (in appropriate languages) about where and how to access these services in their communities.

Also of concern is the scope of information provided to beneficiaries prior to enrollment and the frequency with which information is provided to current enrollees. With respect to potential enrollees, the state need only provide a *summary* of certain information. Whereas the January rules would have required complete information to be provided in the first instance (January § 438.10(d)(2)(ii)), under the proposed rules potential enrollees would have to request detailed information on, for example, the scope of benefits covered and the benefits that are available under the State plan but which are excluded under the managed care contract and where and how to obtain these excluded services. Proposed § 438.10(e)(2)(ii). This information is critical for individuals to make their health care choices, especially individuals for whom one or more participating health plan options limit access to reproductive health services. It is unreasonable to expect that individuals who have to make decisions in short periods of time before being defaulted should have to take extra steps to obtain full information. Full information at the earliest point possible is crucial, especially if women are at risk of being defaulted into plans which do not provide the continuum of care to meet their health care needs.

In addition, the proposed rules further delay when potential enrollees can get this information by requiring that information be provided to Medicaid beneficiaries only when they become eligible to enroll in a voluntary program or are required to enroll in a mandatory managed care program. Proposed § 438.10(e)(1)(i). Under the January rules, potential enrollees were to be given information as soon as they had become eligible for Medicaid. January § 438.10(d)(ii). Depending on the state, the time difference between Medicaid eligibility and mandatory enrollment can be significant, providing needed time for beneficiaries to read, digest, and utilize often complex information describing their health care access choices. Complete information should be provided to individuals in all mandatory and voluntary eligibility categories from the point of Medicaid eligibility. States do or should know who these individuals are as soon as their eligibility is determined. For example, California maintains a very detailed listing of the managed care enrollment status of each eligibility category, by county. There is no reason not to provide this information at the earliest stage to beneficiaries.

As under the January rules, the proposed rules require that soon after enrollment, certain information be provided to beneficiaries. However, the January rules explicitly made the health plans responsible for providing this information. January § 438.10(e)(1). The proposed rules eliminate reference to the responsible party. Proposed § 438.10(f). The State Medicaid agency, as the single state agency, must be held ultimately accountable for the provision of information. States may have discretion to decide whether the State itself will provide the information, or whether it will be the health plans. However, the issue of accountability is a separate issue which should be of concern to CMS. The rule should make the State responsible for either providing required information or ensuring that health plans provide it. Enrollees and potential enrollees should not bear the consequences of lack of compliance by the State or the health plans.

The January rules also required that the information be provided annually thereafter. Under the proposed rules, enrollees will receive annual information only on their *right to request and obtain* this information. *Compare* January § 438.10(e)(1)(i) *with* proposed § 438.10(f)(2). Enrollees should automatically be given accurate, current, and comparable information on an annual basis so that they can, during open enrollment periods, decide whether to stay in the plan or switch to another plan. Over the year, there can be changes in a health plan. Without annual information, enrollees will have to keep track of piece meal changes that may have occurred. Private insurance enrollees typically are given information during this time. Medicaid enrollees deserve no less. Annual information also is important to remind individuals about how to access services, especially those services which are not included in the plan contract.

In the discussion regarding the requirement that enrollees be told of any limits on freedom of choice among network providers (Proposed 438.10(f)(6)), the Preamble states that this information must clearly indicate which providers are available under any subnetworks with which the plan contracts and must explain the procedures under which an enrollee may request a referral to an affiliate provider not included in the subnetwork. 66 Fed. Reg. at 43624. This is important for women who may be obtaining services from a medical group which limits access to reproductive health services. CMS should include this requirement in the regulation.

The proposed rules add § 438.10(f) to require States to notify enrollees of their disenrollment rights at least annually and at least 60 days prior to each open enrollment period. We support this provision.

Enrollee-Provider Communication

A significant omission is a requirement that health plans that exclude coverage of certain counseling or referral services on the basis of moral or religious objections, provide information on those services. Proposed § 438.102(c)(2). We have the same concerns and recommendations as described above under the information requirements - that a sufficient accommodation is provided for these entities by allowing them to exclude these services and that omitting any responsibility to provide information to beneficiaries eliminates the crucial means for women to access information at the point of service. This discounts the moral and religious beliefs and the health care needs of female Medicaid beneficiaries. Female Medicaid beneficiaries should not be discriminated against. They

should at least receive information about a toll-free number that can provide them with needed information.

Disenrollment

The proposed rules include certain reasons for disenrollment for cause that were included in the January regulations. Three of these are important for female enrollees who, while ensured free access to family planning services under the Medicaid Act, may not be able to access those services through their managed care entity. By allowing disenrollment for cause, the proposed rule protects the ability of women to obtain covered family planning and other reproductive health services. Thus, we support including the following as reasons for disenrollment for cause:

(1) the plan does not, because of moral or religious objections, cover the service the enrollee seeks;

(2) the enrollee needs related services (for example a cesarean section and tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

(3) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

See proposed § 438.56(d)(2); January § 438.56(d)(2).

Free Choice of Provider

We support the clarifying language that, under the BBA, beneficiaries have the right to a free choice of provider to obtain family planning services. Thus, beneficiaries enrolled in managed care can seek family planning in or out of network, as long as the provider is a qualified, participating Medicaid provider. Proposed § 431.51(a)(4), (5), (6).

Out-of-Network Access

The proposed rule includes a requirement in § 438.206(b)(4) that if the network cannot provide the necessary services covered under the contract needed by the enrollee, these services must be adequately and timely covered out-of-network for as long as the health plan is unable to provide them. We support this provision.

In addition, whereas the January rules required States to directly ensure that health plans meet this and other access standards, the proposed rule requires only that the state ensure compliance *through their contracts* with health plans. *Compare* January § 438.206(d) *with* proposed § 438.206(b). This change invites States to argue that their monitoring and oversight obligations are complete if the

contract contains the appropriate terms. The rule should be amended to require direct accountability by States.

The proposed rule includes a requirement that the out-of-network services do not result in greater costs to the enrollee than would occur if the services were furnished within the network. We support this provision. Proposed § 438.206(b)(5).

For beneficiaries in rural areas, the January rule would have allowed individuals to access out-of-network providers if the service or type of provider were not available within the health plan. January 438.52(b)(2)(ii)(A). This access provision is included in the proposed rule, except that "type of provider" is defined to mean "in terms of training, experience, and specialization." Proposed § 438.52(b)(2)(ii)(A). We are concerned that this change will allow a health plan to deny out-of-network access if there is a provider who has the training, experience, and specialization in the network, but who may be otherwise unavailable due to, for example, geographic inaccessibility or long waits for getting appointments. The added language should be deleted.

Under the January rules, out-of-plan access also was available in managed care plans in rural areas where a beneficiary has a pre-existing relationship with an out-of-network provider and that provider is the primary source of care for the beneficiary. January § 438.52(b)(2)(ii)(B). In promulgating this January rule, CMS clarified that it applied as long as the provider continued to be the main source of the service. *Id*. In its discussion, CMS stated that the rule would apply to, for example, pregnant women who have initiated prenatal care prior to enrollment. January, 66 Fed. Reg. at 6260. In the proposed rule, CMS would limit a beneficiary to continue this relationship for a maximum of up to 60 days only, during which time the provider would be given an opportunity to join a health plan. If the provider chose not to join or did not meet the qualifications to join, the enrollee is to be transitioned (either by choosing a provider or by assignment) to a health plan provider. Proposed § 438.52(b)(2)(ii)(B). This can cause serious continuity of care problems for pregnant women who have started their prenatal care with an out-of-network provider. Many providers are reluctant to take pregnant women as patients in their second or third trimester, especially if they are perceived as or are high risk. This can be a common issue, especially since there is presumptive eligibility for pregnant women, and presumptive eligibility providers are not always the same as managed care providers. This rule can have the effect of leaving pregnant women with no provider or delaying continued prenatal care. The 60-day limit should be deleted.

The proposed rules also maintain the right of rural enrollees to access services out-of-network where (1) the only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks; (2) the recipient's primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately (for example, a cesarean section and tubal ligation) and not all of the related services are available within the network); or (3) the State determines that other circumstances warrant out-of-network treatment. Proposed §§ 438.52(b)(2)(ii)(C), (b)(2)(ii)(D), (b)(2)(ii)(E); January §§ 438.52(b)(2)(ii)(C), (b)(2)(ii)(D), (b)(2)(ii)(E). We support this provision.

However, we are concerned about the confusing and seemingly contradictory discussion in the preamble in which CMS would not require States to have any fee-for-service access to be in compliance with these out-of-network provisions in rural areas. Allowing individuals to disenroll

from their primary care provider and choose another network provider would suffice to comply with § 438.52(b), as long as the State satisfied the provision of allowing out-of-network access in the case in which the only plan or provider available to the enrollee did not provider certain services due to moral or religious grounds. Proposed, 66 Fed. Reg. at 43627. By not requiring States to have fee-for-service access under all of the circumstances listed, CMS contradicts the rule on its face. In addition, without the ability to contract on a fee-for-service basis, States would not be able to comply with the statutory requirement that individuals be permitted to disenroll from a health plan for cause. The disenrollment for cause requirement is not limited to non-rural areas. Having no fee-for-service access also would undermine enrollees' right to freedom-of-choice of family planning providers, which the BBA specifically preserved. States should be required to ensure access to all services, including by maintaining fee-for-service providers for individuals who are permitted to access out-of-network providers under the statute and regulations and for those who have the right to disenroll for cause. Moreover, unless the State has a waiver, it cannot require certain individuals to enroll in managed care (e.g. Native Americans, children with special needs, etc...). Thus, fee-for-service would continue to be necessary, and CMS should clarify this.

Availability of Services

Section 438.206 of the proposed rule requires each State to ensure that all covered services are available and accessible to enrollees. However, several important provisions which were included in the January final rules were omitted from this section. First, the proposed rules do not require states that limit freedom-of-choice to comply with the requirements of § 438.52 which specifies the choices the State must make available (e.g., a choice of at least two health plans, or, in rural areas, a choice of at least two primary care providers or case managers and out-of-network access under certain circumstances). *Compare* proposed § 438.206 *with* January § 438.206(b). The reason for this omission is not clear, since States would have to comply with § 438.52 by its own terms. However, CMS may be indicating that it does not intend for States to monitor or demonstrate compliance as part of its quality assurance activities. States should be required to demonstrate compliance with this fundamental requirement. CMS should clarify this intent.

Second, the proposed rule does not include the explicit requirement that for services under the state plan but not covered in the health plan contract, States must make those services available from other sources and provide to enrollees information on where and how to obtain them including how transportation is provided. *Compare* proposed § 438.206 *with* January § 438.206(c). The State, under other provisions, would have to provide information about where and how to obtain services not provided by the health plan due to moral or religious objections, and on how to obtain services from out-of-network providers. *See* proposed §§ 438.10(f)(6)(vii), (f)(6)(xii); proposed 66 Fed. Reg. at 43629. In addition, under other provisions of the Medicaid statute, States would have to ensure continued access to services not included in the plan contract. *See, e.g.,* 42 U.S.C. §§ 1396a(a)(8)(reasonable promptness), 1396a(a)(10)(A)(required services to certain categories of Medicaid beneficiaries). However, this provision was a clear statement of the State's responsibility and it should be included.

Implementation of this provision would avoid confusion and delay in assisting enrollees to access these services and in holding States accountable for ensuring access to services carved out of plan contracts. CMS already acknowledges this State obligation in the preamble to proposed rules. 66 Fed. Reg. at 43629 (making clear that the State is responsible for ensuring access to all covered services when health plans avail themselves of this religious opt out provision.). Therefore, it makes no sense for the requirement to be omitted, and the omission suggests that CMS does not expect any accountability from States, allowing "the less-than state plan contract" services to be the scope of services available to managed care enrollees by default. CMS has no authority to limit access to these services. A provision to require States to make services not included in the plan contract available through fee-for-service or other contracts and to provide information on how to access these services should be included in the final rule.

Specific delivery network requirements also were left out. The proposed rules do not require States to ensure that each health plan pay particular attention to pregnant women and other individuals with special needs in maintaining and monitoring their provider network; that health plans seeking to expand their service areas demonstrate that they have the sufficient numbers and types of providers to meet the anticipated volume and types of services enrollees will require; and that providers do not discriminate against Medicaid enrollees. *Compare* proposed § 438.206(b) *with* January § 438.206(d). These are basic requirements that any health plan should be required to follow. Most individuals in Medicaid managed care are women of childbearing age and their children. If health plans cannot demonstrate appropriate provider networks to meet the continuum of their needs, they should not participate at all. Thus, these network requirements should be included.

Direct Access to Women's Health Specialists

The proposed rule includes language regarding direct access to women's health specialists for female enrollees for women's routine and preventive care. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist. Proposed § 438.206(b)(2). We support this inclusion.

What is not included is a definition of what constitutes "routine and preventive services" which female enrollees can access from women's health specialists. CMS should clarify that these services include (but are not limited to) visits for family planning, prenatal care, mammograms, pap smears, and for services to treat genito-urinary conditions such as vaginal and urinary track infections and sexually transmitted diseases.

Screening, Assessment, and Treatment Planning

Identification*:* The January rules listed individuals who must be identified as "at risk" for whom health plans must provide initial screens, follow-up assessments and treatment planning. These persons included enrollees known by the State to be pregnant. CMS also placed the burden on the States to identify these individuals to the health plans upon their enrollment. January, § 438.208(b); 66 Fed. Reg. at 6308.

The proposed rule would require only that "individuals with special health care needs, as specified by the State," be identified. Proposed § 438.208(b). Thus, states could exclude pregnant women from being screened and assessed in a timely manner. We request that the language of the January rule be included. Early identification of pregnant women is key for good birth outcomes and for maternal health.

Screenings and Assessments*:* In the January rule, CMS differentiated between the terms "initial screening" and "comprehensive health assessment." The initial screen must have been sufficient to identify individuals with special needs and to identify languages, TTY requirements, and needs for accessible medical facilities and/or transportation services. A comprehensive health assessment included a physical examination by an MCO or PHP provider. January, 66 Fed. Reg. at 6309.

The proposed rule makes no distinction between screenings and assessments. The fact that CMS would give States the discretion to use their own staff or their enrollment brokers in lieu of health plan health care professionals indicates that CMS would permit that no initial health assessment be done at all, not only for pregnant women, but for any individual with special needs. Proposed § 438.208(c), 66 Fed. Reg. at 43635. The final rules should include a health assessment soon after enrollment to identify pregnant women's health care needs and course of treatment.

Time frames*:* Under the January rules, each health plan would have been required to perform screening within 30 days of the enrollee being identified as "at risk" by the State. For all other enrollees, the health plan would have been required to screen within 90 days of enrollment to determine whether the enrollees are pregnant or have special health care needs. The health plan also would need to have ongoing mechanisms to identify enrollees who develop these conditions.

For any screened enrollee identified as being pregnant or having special needs, the health plan would have been required to provide a comprehensive health assessment as expeditiously as the health condition required, but no later than 30 days from the date of the identification. For enrollees identified by the State as being pregnant, or to have self-identified as being pregnant or to have special health needs, the health plan would have been required to provide a comprehensive health assessment within 30 days without needing an initial screen. January, § 438.208(d), (e).

None of these time frames was included in the proposed rules. *Compare* proposed, § 438.208(c) *with* January § 438.208(d), (e). Without time frames, there is no way to measure compliance or to hold health plans accountable. These time frames should be included if there is to be any compliance and accountability for providing screens, assessments, and treatment plans.

Treatment Planning: January § 438.208(f) set forth rules for health plans to develop and implement treatment plans for pregnant women and other enrollees with special needs. The treatment plan would have been required to be appropriate for the conditions identified and for a specific period of time and updated periodically; and specify a standing referral or an adequate number of direct access visits to specialists. The January rule also required that the treatment plan ensure appropriate coordination of care among providers; be developed with enrollee participation; and ensure periodic reassessment of each enrollee as his or her health condition requires. January, § 438.208(f)(3)-(4); 66 Fed. Reg. at 6310-11. In addition, health plans were to use "appropriate health care professionals" to

perform assessments and to develop, implement and update treatment plans. January, § 438.206(g); 66 Fed. Reg. at 6312.

The proposed rule does not include any of these requirements and instead only requires States to ensure that health plans have a mechanism in place for individuals determined to have ongoing special conditions that require a course of treatment or regular care monitoring to have direct access to specialists, either through a standing referral or an approved number of visits, as appropriate for the enrollee's condition and identified need. Proposed § 438.208(d)(1). In addition, *only if the health plan requires it*, will a treatment plan be developed. If so, then the State must ensure that the health plan has a mechanism to develop the treatment plan with enrollee participation; to approve the plan in a timely manner (if necessary); and to ensure that the treatment plan is in compliance with the State's quality assurance and utilization review standards. *Id.* § 438.208(d)(2). It is important to emphasize that the proposed rules do not require that this process occur for each individual with a special need, only that the State ensure that mechanisms are in place to develop treatment plans which *health plans* require. Thus, conceivably, a health plan can determine that no treatment plan is required for anyone and there would be no consequence. We, therefore, urge inclusion of the January formulation.

In response to concerns about individuals with ongoing health care needs, including pregnant women, who are transitioning to managed care, CMS added January § 438.62(b) which would have required States to have a mechanism to ensure continued access to services. These requirements would have applied to individuals transitioning from fee-for-service to managed care, from one managed care plan to another, or from managed care back to fee-for-service. CMS believed that this provision, along with the requirements in § 438.208 requiring identification of persons with special needs, screening, assessments, and treatment planning, addressed continuity of care concerns. January, 66 Fed. Reg. at 6311, 6313. CMS failed to include this protection in the proposed rule. Proposed, § 438.62. This provision should be included.

The proposed rules make the requirement to develop treatment plans of little or no value. They give health plans complete discretion to determine whether a treatment plan is even warranted. It would be surprising if this regulation were not completely ignored. CMS, to demonstrate its commitment to treatment planning, should indicate the individuals for whom health plans must develop and implement treatment plans. This group should include pregnant women, particularly those at high risk, such as pregnant women with gestational diabetes or with a history of miscarriages.

Liability and Cost Sharing

The proposed rules include language clarifying that enrollees may not be held liable for covered services. This rule applies to services for which the health plan is contractually responsible and for which the State fails to pay the health plan or the State or the health plan fails to pay an individual provider who furnishes the service under a contractual, referral, or other arrangement. Proposed § 438.106(b). In addition, for contract services provided under a contractual, referral or other arrangement, an enrollee cannot be held liable for any payments in excess of what the enrollee

would owe if the health plan had provided the services directly. Proposed § 438.106(c). We support inclusion of these provisions

A separate cost sharing provision makes clear that any cost sharing imposed must comply with the same cost sharing requirements as under fee-for service.[(1)] *See* January § 438.108, 66 Fed. Reg. at 6282-83; proposed § 438.108, 66 Fed. Reg. at 43630. This includes only nominal co-payments, no co-payments imposed on children and pregnant women, and no co-payments for family planning and emergency services. *Id*; 42 C.F.R. §§ 447.53(b), 447.54. We support this provision.

In addition, services that are accessed out-of-network due to the health plan's inability to provide needed services may not result in greater costs to the enrollee. Proposed § 438.206(b)(5). We support this provision.

Specification of Contract Benefits

Section 438.210(a) of the January rule requires contracts to clearly specify those services which the health plan is responsible for providing. This requirement also specifically applied to MCOs, PHPs and PCCMs. January, § 438.210(a). Prior to the BBA, there was no such requirement. The degree to which benefits are specified within contracts has varied considerably from state-to-state and within the same state.[(2)] The proposed rule would keep this requirement, but would exclude PCCMs and PAHPs from the requirement. Proposed, § 438.210(a). There is no reason for PCCMs and PAHPs to be excluded from this requirement. Seemingly, it would be even more important for these entities, which provide only a subset of state plan services, to have clearly defined contracts in which the scope of services for which they are responsible is clearly outlined. This is also important in the case of plans that exclude services to which they have a moral or religious objection.

Prior Authorization Request Processing

The proposed rule fails to include any requirement that health plans and subcontractors have in place and follow written policies and procedures for processing prior authorization requests which reflect current standards of medical practice. *Compare* January, § 438.210(b)(1), *with* proposed, § 438.210(b)(1). Health plans should not be able to provide care that does not meet current standard medical practices. Without this requirement, CMS would allow health plans participating in Medicaid to provide lower levels of care. Current medical standards should be a minimum that all health plans should meet.

Limitations on Payments to Providers

In order for a State to pay providers for family planning and other services that are included in the plan contract, but which individuals access out-of-network, the State must make a reconciliation or adjustment to the capitation payments made to the health plan. Proposed § 438.60. This may continue to cause administrative and payment barriers for beneficiaries to receive family planning

and other services out-of-network if the health plan is supposed to otherwise provide the service. There need to be stronger protections for payment for services provided out-of-network, including family planning and other reproductive health services. Without a mechanism for timely payment for out-of-network providers, the right of beneficiaries to access these services will be illusory. Therefore, States should be made to pay for these services promptly for which they can, perhaps, later deduct from future managed care capitation payments or make other arrangements that do not delay payment.

Confidentiality

The proposed rule requires only that States ensure "through their contracts" that for medical records and any other health and enrollment information that identifies a particular enrollee, health plans have procedures in place that meet the requirements of 45 C.F.R. parts 160 and 164, the HIPAA privacy regulations. Proposed § 438.224. CMS should clarify that State monitoring and oversight does not end with inclusion of contract language.

Conclusion

The proposed regulations, if implemented, would significantly weaken protections and responsibility for ensuring reproductive health and other service access. We object to CMS ignoring the January final rules which were promulgated after an extended public process under the Administrative Procedures Act in which all stakeholders had an opportunity to participate. These proposed regulations reneges on a tacit agreement that was made with consumers - if consumers were to give up their right to vote with their feet, then they should have strong protections. The January final rules strike this balance among the needs of consumers, States and contracting entities. The proposed rules would disrupt this balance, limiting consumer choice with fewer consumer protections, allowing discrimination against women's health services, and undermining accountability for the program and for taxpayers dollars.

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Please contact Lourdes Rivera, 310-204-6010 x 3011, rivera@healthlaw.org, or Mara Youdelman, 202-289-7661, youdelman@healthlaw.org, if you have any questions regarding the above comments.

Submitted on behalf of:

The Alan Guttmacher Institute
American Civil Liberties Union
American Federation of State, County and Municipal Employees
Birthing Project USA
California Pan Ethnic Health Network

California Women's Law Center
Citizen Action of New York
Community Healthcare Network (New York, NY)
Family Planning Advocates of New York State
Gay Men's Health Crisis (New York, NY)
Greater Upstate Law Project, Inc.
Medical and Health Research Association of New York City, Inc.
Merger Watch
Mexican American Legal Defense and Educational Fund
Michigan Association for Children with Emotional Disorders
Michigan Association for Infant Mental Health
National Abortion and Reproductive Rights Action League, NY Affiliate (NARAL/NY)
National Center for Youth Law
National Health Law Program
National Latina Health Organization
National Women's Law Center
Northwest Health Law Advocates (Seattle, WA)
Planned Parenthood of New York City
Public Justice Center (Baltimore, MD)
Virginia Poverty Law Center
Women's Health and Family Planning Association of Texas
Women's Health Specialists (Chico, CA)

1. The BBA amended the Medicaid statute to permit cost sharing for managed care enrollees to the same extent as under fee-for-service. *See* 42 U.S.C. § 1396o(b), *as amended by* The Balanced Budget Act of 1997, § 4708(b).

2. See Jane Perkins & Kristi Olson, National Health Law Program, *An Advocate's Primer on Medicaid Managed Care Contracting*, 31 Clearinghouse Rev. 19 (May-June 1997). Sara Rosenbaum, *et al.,* The George Washington University Medical Center, Center for Health Policy Research, *Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts* (Feb. 1997).