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NATIONAL HEALTH LAW PROGRAM

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Cindy Mann
Deputy Administrator and Director
Center for Medicaid, CHIP, and Survey and Certification
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Cindy:

We write to you to provide additional recommendations regarding the definition of Essential Health Benefits (EHB) for Medicaid benchmarks. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels.

We have written to you previously about the EHB standard, and more recently, with recommendations to strengthen the underlying § 1937 Medicaid benchmark plans that states will select to cover the Medicaid Expansion population (a copy of our letter dated May 16, 2012 is attached). We suggested that CMS create objective minimum standards and a transparent process for establishing Secretary-approved coverage, the likely vehicle for the majority of state Medicaid benchmark proposals. We also indicated our agreement with CMS' conclusion in guidance that Medicaid benchmarks must comply independently with both the § 1937 benchmark requirements *and* the ACA's EHB requirements.

Since our May 16 letter, CMS guidance has indicated that CMS will establish a separate EHB-reference standard for Medicaid (in addition to the one already being developed for the Exchange). NHeLP agrees that CMS should implement an EHB definition specific to Medicaid. This is an opportunity to develop a strong and uniform national EHB benefit standard for Medicaid benchmarks. The flexibility allowed in the EHB standard for the Exchanges and private market is not acceptable for the Medicaid population, which has higher needs.[1] Therefore CMS must set a higher bar

[1] The Medicaid Expansion population is a low income population. In 17 states this will include parents living below *half* of the poverty line, and for childless adults it will include individuals with *no income whatsoever* in the vast majority of states.

for coverage in order to meet the specific needs of this population.[2] The Medicaid EHB definition should also include some of the important protections already proposed for the Exchange EHB definition, such as the inclusion of PHSA § 2713 services.

In order to meet the needs of the Medicaid Expansion population, CMS should define the Medicaid EHB standard to require that every state supplement the underlying § 1937 benchmark plan selected by the state with all of the Medicaid state plan services in the ten statutory EHB categories. For example, if a state selects an FEHBP-equivalent plan for its Medicaid benchmark, it should supplement the FEHBP "maternity and newborn care" benefits with all of the Medicaid state plan maternity and newborn services. (It should also do the same thing in each of the other nine EHB statutory categories of coverage).

We note that Congress thoughtfully developed the Medicaid state plan benefit considering the needs of low income individuals. Now that the Medicaid benchmark will be a broad state plan coverage vehicle, it makes sense for traditional state plan services to set the floor for Medicaid EHB and benchmark adequacy. Using Medicaid state plan services as the Medicaid EHB standard will also promote alignment between the Medicaid Expansion and other state plan categories.

When referencing the "Medicaid state plan services," the state should rely on the Federal definition in law and regulation for scope of services, and not any state interpretation (or waiver) that is more restrictive. This should apply to both the list of coverable services as well as amount, duration, and scope of services. For example, rehabilitative services, as described in § 1905(a)(13), are defined in 42 CFR §440.130(d), and the state must be required to use that definition in the Medicaid benchmark. Such a policy would create a strong and uniform national standard ensuring adequate coverage for this extremely vulnerable population.

States should additionally be required to evaluate, on a regular basis, whether the Medicaid benchmark is meeting the needs of the Medicaid population with respect to the ten statutory EHB categories. For example, it is possible that even *after* being supplemented with the Medicaid EHB reference services, a Medicaid benchmark might still have inadequate coverage of habilitative services. CMS should require that states define and update the Medicaid EHB standard through a robust stakeholder process, including publicly posting Medicaid EHB proposals online and then initiating a public comment process (as is the case with § 1115 demonstrations and the recent dual eligible integration proposals). If this process identifies gaps in the Medicaid benchmarks (as supplemented by the Medicaid state plan benefit), the Medicaid EHB standard should be supplemented (through the same or similar process including

[2] A 2011 report from the Centers for Disease Control shows that low-income individuals are much more likely to suffer from two or more chronic conditions (p. 40), limitations in activity (p. 41), diagnosed diabetes (p. 188), poorly control diabetes among those who are diagnosed with diabetes (p. 189), heart disease or a stroke (p. 186), joint pain, knee pain, shoulder pain, and hip pain (p. 196-198), vision limitations and hearing limitations (p. 203), fair or poor health (self-assessed) (p. 205), and depression (p. 38). Centers For Disease Control and Prevention, *Health, United States, 2011*, available at: http://www.cdc.gov/nchs/data/hus/hus11.pdf.

consumer stakeholders) with services necessary to fill those gaps and meet the needs of the Medicaid population.

We recommend that the EHB standard developed for Medicaid also be used for the Basic Health Plan (BHP) population, given that BHPs are also intended to target low-income populations.

Regardless of the EHB definition, Medicaid benchmarks are still Medicaid benefit packages governed by Medicaid law. Therefore, they must still comply with all generally applicable Medicaid requirements, including EPSDT, amount, duration, and scope, due process (including notice and appeal rights), cost-sharing protections, and utilization management limits. This also includes all § 1937 requirements, such as the requirements for mental health parity and coverage of family planning services and supplies. Furthermore, all § 1937 benchmarks must continue to be prohibited from enrolling statutorily exempted populations, except at the active ("opt-in") and informed choice of an individual. States should only be allowed to passively enroll exempt individuals into Medicaid benchmarks when the Medicaid benchmarks include all state plan benefits the individual might otherwise be eligible for.

Finally, we note that, independent of the Medicaid EHB standard, current regulations require that Secretary-approved coverage "meets the needs" of the covered population. (We believe this supports our suggested framework for defining Medicaid EHB.) We recommend that CMS issue guidance that applies this requirement to all Medicaid benchmarks options and that CMS define how a benefits package will be evaluated for compliance with the requirement and what benefits must be included. Such guidance could help ensure that the intent of CMS' regulation truly results in the policy objective of benchmarks meeting the needs of covered individuals.

NHeLP would like to meet with you to discuss our recommendations further. Please do not hesitate to contact Leonardo Cuello (202-289-7661; cuello@healthlaw.org) if you would like to set up a meeting, have any questions, or would like any further information. NHeLP is grateful for the consideration of our recommendations and the effort you and CMS staff make to improve the lives of Medicaid enrollees.

Sincerely,

Emily Spitzer,
Executive Director