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March 13, 2008

Department of Health and Human Services

Attention: CMS-2232-P

P.O. Box 8016

Baltimore, MD 21244-8016

Reference: CMS-2232-P

Dear Sir:

The following comments on the proposed rule, published in the Federal Register on Friday, February 22, regarding the Medicaid Program's State Flexibility for Medicaid Benefit Packages are submitted by the Bazelon Center for Mental Health Law. The Bazelon Center is a legal advocacy organization concerned about the rights of adults and children with serious mental disorders.

Section 440.305(c) & Section 440.315: Scope

These sections allow states to apply the option for benchmark or benchmark-equivalent coverage to individuals who, under the Act, may not be required to enroll in such plans.

This shift of Medicaid beneficiaries into plans that may have coverage far different from Medicaid is a major change in policy and alters in a fundamental way the basic Medicaid program that has been in effect since 1965. It is therefore critical to approach such a drastic change with caution.

The law permits many groups of Medicaid-eligible persons to be enrolled in these plans, but specifically exempts the most vulnerable of populations from mandatory coverage. These exemptions include persons with disabilities, children in the foster care system, medically-needy and medically frail persons. Congressional action to create these exempted groups reflects the fact that these groups include many children and adults with serious health disorders, including serious mental disorders, for whom the broad coverage of traditional Medicaid is essential.

The benefit packages in private insurance plans, such as those listed as

benchmarks under the law, frequently have limited coverage of mental health services. Generally, such plans cover outpatient clinical services and inpatient hospital care. Few cover any of the intensive community services that are covered by Medicaid under the rehabilitation category or home and community-based services option. In addition, even the covered services are generally limited – with annual limits on inpatient days and outpatient visits and higher cost sharing than that required for other health services. Under the DRA, these limited mental health benefits can be further reduced by 25 percent of their actuarial value.

For persons in the eligibility groups exempted under the law, this kind of coverage is totally inadequate. Individual needs will not be met, people will get sicker and go into crisis more often and utilization of both inpatient and community services will increase over the long-term.

Once enrolled, many individuals in these eligibility groups are likely to stay enrolled in their inadequate benchmark plan because they will not have the ability to assess the impact of this plan on their health, or will not fully understand, their right to opt-out. Enrollment for even a short time in an inadequate plan may be extremely detrimental to some individuals' health.

We strongly recommend that subsection (c) be struck and section 440.315 amended, to ensure that states are not allowed to enroll any of the exempt populations in these plans.

Section 440.315 Definition of Individuals with Special Medical Needs

The preamble to the proposed rule requests suggestions regarding the definition of individuals with special medical needs. We would urge that this category include adults who meet the federal definition of an individual with serious mental illness and children who meet the federal definition of children with serious emotional disturbance, as promulgated by the Substance Abuse and Mental Health Services Administration. These definitions require not only a diagnosis of mental disorder, but also that the disorder have a minimum duration and the individual also be found to have significant limitations in his or her functioning.

The SAMHSA definition would include some individuals who, for one reason or another, are not eligible as persons with a disability, but nonetheless are significantly impaired by their mental disorder.

Benchmark coverage is likely to prove entirely inadequate for these individuals, even though the individual may fall into an eligibility category that can be mandated to enroll in a benchmark plan. Children with serious mental disorders often qualify for Medicaid on the basis of family income and are not, for various reasons, receiving Supplemental Security Income (SSI) benefits or otherwise recognized as children with disabilities. Many low-income parents on Medicaid have been found to have serious depression, which could not be adequately treated with a very limited mental health benefit.

Section 440.320 Benchmark Health Benefits Coverage

This section requires states to comply with certain provisions if they intend to enroll exempt groups in benchmark or benchmark equivalent plans. If CMS continues to authorize enrollment of these individuals, then these provisions will be extremely important.

This section should clarify that individuals in the exempt populations must not be enrolled by the state in benchmark plans, but must instead affirmatively opt-in themselves. The proposed rule uses the term “opt in” to refer to the process of states enrolling exempt populations in benchmark plans. According to the preamble to the rule, CMS considers the rule to be implementing the policy and guidance used to guide states up to now. However, some states have acted to enroll individuals in these plans, forcing them to opt-out. This is a very different situation than one where the individual makes an affirmative choice to enroll. Moreover, it is not clear that these states have provided a full description of the benefits of the benchmark plan and basic Medicaid, potentially leading beneficiaries to elect to stay in a plan that is not in their best interest.

CMS should also monitor the states’ actions more closely to both ensure that no one in an exempt eligibility group is automatically enrolled by the state in such a plan and that the states assist beneficiaries who may wish to opt-in by providing full and clear detailed information on the benefits covered and cost sharing imposed under each option.

The documentation in the exempt recipient’s file should include a communication from the individual to indicate that he or she has received the required information and that they choose to enroll in the benchmark or benchmark equivalent plan.

Section 440.330 and Section 440.335 Benchmark Health Benefits Coverage

One reason states may wish to design a plan under the option for benchmark-equivalent or secretary-approved coverage is to offer beneficiaries important services that are not otherwise covered by Medicaid or a standard benchmark plan. This rule does not permit this. It would be advisable for CMS to allow states to submit proposals that include other services, and to judge the overall plan proposed by the state to assess its efficiency. For example, coverage of some preventive services or supportive services that are not costly could greatly enhance the benefit package and potentially reduce spending on other services.

The purpose of this section of the law is to allow states greater flexibility in tailoring benefit packages. By limiting services to those in a benchmark plan or in traditional Medicaid, CMS is undermining this principle.

We recommend that states have the opportunity to make a case to CMS that expanding some services by use of a benchmark-equivalent or secretary-approved plan is in the best interests of participants and the federal and state governments.

Section 440.345 EPSDT Services Requirement

States that have adopted benchmark plans to date have provided very little information about

how they will meet the EPSDT mandate to provide children all medically necessary services covered under the Act. This rule does not ask the states to do more than describe how the wrap-around EPSDT benefit will be provided.

As it stands now, families are unlikely to realize that their children have access to more coverage than that provided through the benchmark plan. Even if they understand this right, they may not know how to request such a service.

This section should be strengthened by requiring that states explain, in detail, how a family will be informed about their rights under EPSDT once they are enrolled in a benchmark plan and to explain the specific process the state will then go through to approve (or disapprove) these services. States should also explain timelines for consideration of EPSDT requests in emergency, urgent and routine cases.

Section 440.350 Employer-sponsored insurance health plans

This section fails to state that if the state chooses to provide benchmark plan coverage by obtaining employer sponsored health plan coverage it must nonetheless still ensure that children have access to the wrap-around EPSDT benefit.

This section of the rule should be amended to clarify that states must provide a wrap-around benefit that enables children to receive all medically-necessary Medicaid services, in order to continue to meet their obligations under the EPSDT mandate of the law.

Section 440.360 State plan requirement for providing additional wrap-around services

When individuals receive a limited benefit under their benchmark plan, but then need to access additional services as a wrap-around benefit (including children for whom wrap-around benefits are mandated), states should be required to ensure they continue to be able to receive services from the same provider. This is particularly important in mental health care. First, the therapeutic alliance between a patient and a provider is crucial to good patient outcomes. Secondly, benchmark plans may often have limits on the number of outpatient visits or inpatient days that are covered. When an individual needs an extension of these visits or days using the state's wraparound benefit, it makes no sense to force them to change providers.

The rule should be amended to emphasize that states must show how they will ensure continuity of care in order to ensure quality and efficiency in these situations.

Section 440.390 Assurance of Transportation

CMS has chosen to consider access to transportation for non-emergency care an optional service that need not be provided to individuals enrolled in benchmark plans. This is an unnecessary

and harmful extension of the provisions in the DRA.

Low income individuals frequently have difficulty in making their medical appointments for various reasons, including their necessary reliance on unreliable and sometimes unavailable public transportation. Added to the difficulties faced by all low income people, people with serious mental illness may be unable to manage public transportation due to factors related to their illness. The foreseeable result of dropping transportation for these groups of people is a failure to furnish necessary services for the many individuals who will be unable to get to the appointments.

In the long run, this is counter-productive for all concerned. Non-emergency transportation is a critical component of Medicaid, even though it is rare for it to be covered in any other type of insurance plan. This is just one way in which Medicaid is specially adapted to meet the needs of the populations it serves and to act as a safety net health care program.

Section 440.390 should be deleted from the rule.

Thank you for the opportunity to comment on this proposed rule.

Sincerely,

A handwritten signature in cursive script that reads "Chris Koyanagi".

Chris Koyanagi
Policy Director