



March 24, 2008

Mr. Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS 2232-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-2232-P-Medicaid Program; State Flexibility for Medicaid Benefit Packages

Dear Mr. Weems:

The American Public Human Services Association and its affiliate, the National Association of State Medicaid Directors, respectfully submits this comment letter on the proposed rule for State Flexibility for Medicaid Benefit Packages published in the February 22, 2008, *Federal Register* (73 FR 9714) for the Centers for Medicare and Medicaid Services.

Please be assured that APHSA and NASMD strongly support and appreciate CMS' stated intention to implement these provisions of Deficit Reduction Act of 2005 in a manner that is designed to preserve the full flexibility offered by Congress. The comments contained in this letter provide support for certain CMS interpretations of the DRA provisions. These comments also identify provisions of the proposed regulations that we believe may be overly restrictive or otherwise prevent the most effective implementation of the DRA provisions.

We commend CMS for having provided guidance on several components of these new provisions, even before publishing the formal regulations. We note that these particular provisions of the DRA have not, to date, been taken up by a large number of states. The publication of final rules may encourage more states to experiment with the flexibility provided in the DRA with regard to cost-sharing and benefit design. However, it should also be noted that the specifics of the statutory language have provided fairly narrow opportunities for implementing many of the new provisions. That is, many high cost populations are excluded from the flexible provisions, and the greatest flexibility is often targeted to higher income populations, which do not make up the bulk of Medicaid consumers in most states. However, that said, it is certainly important, and consistent with Congressional direction, that the new provisions be implemented in a way which preserves maximum flexibility for states which choose to develop alternative approaches to benefit design and cost sharing.

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Comments on Provisions of the Proposed Rule

Populations Affected

NASMD and APHSA support CMS's interpretation that individuals which may qualify for benchmark or benchmark-equivalent coverage packages means an eligibility category listed under section 1905 (a) of the Act and that all recipients within a covered category would be eligible to participate in a benchmark plan at the State's option, unless specifically exempted by statute, even when the State makes modifications to the income and resource eligibility levels for a group or groups under such an eligibility category after February 8, 2006.

§ 440.310 And § 440.315 Eligibility Categories

Section 440.310 and 440.315 implement strict restrictions on the individuals that can be enrolled in benchmark plans. These restrictions largely reflect statutory provisions, but they have the discouraging effect of exempting many beneficiaries and leaving only the least expensive populations eligible for mandatory enrollment in benchmark plans. CMS points out that benchmark plans might be designed with additional benefits that would be attractive to populations that may opt in to benchmark plans, and this is an important option as states consider alternatives for encouraging disease management and other more effective service delivery options. However, these restrictions may result in the need for additional screening of beneficiaries. States may be discouraged from pursuing this option because of both the extra work for determining eligibility, along with the fact that potential savings may be limited. NASMD and APHSA strongly urge CMS to not impose any additional definitions of sub-groups that must be identified and carved out of benchmark plans.

We ask for additional clarification of the phrase "(or being treated as being blind or disabled)" in Section 440.315.

§ 440.345 EPSDT Requirement

NASMD and APHSA support the proposed regulation that would require individuals to first seek coverage of EPSDT services through the benchmark or benchmark equivalent plan before seeking coverage of services through wrap-around benefits. This is important to preserve the legitimacy of pricing for benchmark plans.

§ 440.370 Cost-Effectiveness

APHSA and NASMD also submit that there is a potential for the requirements in 440.370 could have the potential to lead to beneficiaries cycling through benchmark plans to take advantages of benefits in different benefits that each provides. The regulation states "...the same procurement requirements, or other economy or efficiency principles would apply to this coverage as would apply to the purchase of managed care coverage as under the managed care rules at part 438 of our regulations." We are concerned that applying all of the Medicaid managed care requirements contained in 42 CFR 438 will undermine the intent of the DRA to bring market principles and private sector innovation into the provision of Medicaid-funded services.

One of the standard Medicaid managed care requirements (see 42 CFR 438.56.(c)(2)(i)) requires that all newly-enrolled members be allowed 90 days from date of assignment to change managed care plans “without cause,” and a related requirement (see 42 CFR 438.56.(d)(2)(iii)) allows beneficiaries to switch plans at any time due to “lack of access to services covered under the contract.” In a traditional Medicaid managed care program with multiple health plans there is little meaningful variation in benefits across plans, and these provisions help to protect beneficiaries’ access to Medicaid services. They are a built-in enforcement mechanism for a uniform set of benefits. However, through the DRA Congress has encouraged states to create benefit packages more consistent with traditional insurance in the private marketplace, and this flexibility explicitly supports variation in the benefits offered by each health plan. In a market-oriented program of health plans benchmarked to a private-sector standard for health benefits, variations in benefits may well be the basis for a beneficiary’s selection of health plan.

For example, *MCO A* in a benchmark program may offer dental care but reduced vision care, while *MCO B* may offer better vision coverage and reduced dental benefits. If the requirements of 42 CFR 438.56.(c)(2)(i) and (d)(2)(iii) are applied, the beneficiary could choose plan A, receive full dental benefits, then switch to plan B within the first 90 days to obtain its richer set of vision benefits. Or, after the first 90 days, that beneficiary could switch to plan B for cause based on their lack of access to full (and, presumably needed) vision benefits under plan A. In each case, the beneficiary’s ability to switch health plans based on the type of benefits offered subverts the trade-offs inherent in their initial choice of MCO, and subverts the financial trade-offs that the respective MCOs have taken on as a requirement of their participation in the Medicaid-funded program.

If beneficiaries covered by DRA benchmark coverage, rather than full Medicaid benefits, can pick and choose benefits during an enrollment period by plan-hopping, plans will have no way to establish cost-effective premiums tied to the limited benefit package. This will undermine the cost-savings intended by Congress in establishing state plan authority to offer reduced and varied benefits. In this regard, the application of pre-existing Medicaid managed care regulations is inconsistent with Congressional intent in establishing benefit flexibility in the DRA.

APHSA and NASMD urge CMS to allow states to deviate from the lock-in provisions of Medicaid managed care regulations contained in 42 CFR 438. In support of a competitive benefit structure and to align program development with traditional insurance coverage, APHSA and NASMD request that CMS allow states operating a managed care program under DRA benchmark authority to offer as little as a 30-day change period after initial assignment, and that differences in covered benefits be excluded as a justifiable cause for beneficiaries to switch health plans after the change period.

Conclusion

APHSA and NASMD appreciate the opportunity to comment on this Notice of Proposed Rulemaking. We must note that we find a 30 day comment period discouraging of full review and consideration by states. While the proposed rule does seem to offer new options for flexibility for states, there are certain amendments that could make this regulation more accessible. Thank you for considering our comments. If you have any additional questions, please contact Barbara Coulter Edwards, NASMD Interim Director at (202) 682-0100.

Sincerely,



Jerry W. Friedman
Executive Director
American Public Human Services Association



David Parrella
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