



February 21, 2013

VIA ELECTRONIC SUBMISSION

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

Attention: CMS-2324-P
Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing

Dear Sir/Madam:

I am writing on behalf of CSH. CSH is a nonpartisan, nonprofit organization and Community Development Financial Institution that helps communities and states reorient systems and leverage resources to create supportive housing. Supportive housing has been shown to house and stabilize vulnerable people who have experienced homelessness or were at risk of falling into homelessness.

We appreciate the opportunity to comment on CMS' recently released proposed rule regarding Medicaid and health exchange eligibility, enrollment and benefits. Under the Affordable Care Act, most homeless and at-risk populations will now be Medicaid-eligible. It is vital that people can enroll and access benefits as efficiently as possible, and that the benefits offer are meaningful to vulnerable Americans. Our comments concern the following:

- Former Foster Care Children (Section 435.150)
- Certified Application Counselors (Sections 435.908 and 457.330)
- Verification and Documentation (Sections 435.952, 435.407 and 435.952)
- Presumptive Eligibility Determined by Hospitals (Section 435.1110)
- Essential Health Benefits in Alternative Health Plans (Expanding Exempt Populations) [Section 440.315(f)]
- Flexibility in Benchmark health benefits coverage (Section 440.330)
- Cost Sharing (Sections 447.51, 447.52, 447.53, 447.54, 447.55)

§ 435.150 - Former foster care children

Consistent with comments submitted by the National Health Law Program and the National Alliance to End Homelessness, CSH has concerns regarding this provision. This provision will require that young people in foster care be enrolled in Medicaid the day reaching age 18 (or older if the elected by the state) to maintain Medicaid eligibility until age 26. Numerous circumstances exist where individuals may be eligible but not enrolled in Medicaid on their 18th birthday or the day they age out of foster care, and such individuals should not be penalized under this regulation. State administrative error, termination if an individual has left a placement, and termination when an individual becomes an inmate of a public institution are examples of these circumstances, and could all lead a young adult to fall through the Medicaid safety net under the proposed rule. We recommend replacing this rule with a strong commitment to ensure former foster youth are able to access Medicaid.

In addition, the proposed rules include a “state option” to insure former foster children who were enrolled in Medicaid in another state when they aged out. So an individual who aged out in Maryland would be Medicaid-eligible in Pennsylvania only if Pennsylvania decided to include the individual as an eligible population. Providing Medicaid as “an option” for young people aging out of foster care restricts the rights of individuals to travel freely among the states, if they choose to move to a state that happens to have rejected this option.

Access to Medicaid for youth exiting foster care is essential. Foster children have high rates of chronic illness such as asthma, diabetes and mental illness¹. Particularly in the case of those with mental illness, these conditions often do not present until late teens or early adulthood and losing mandatory benefits would result in delayed diagnosis and treatment. People exiting foster care are also at high rates of neurological problems and developmental disabilities, and have very high rates of homelessness. In fact, evidence indicates that approximately 25% of people who have been in the foster care system fall into homelessness. Lack of access to care is one of the reasons former foster youth also have higher risks of homelessness and other poor outcomes.

Furthermore, foster children who are placed out-of-state or seek to relocate due to job or college opportunities would be unfairly disqualified from this group unless the state takes up the proposed option. A young adult may not know to check or how to check whether their destination state has decided to provide Medicaid, prior to moving and subsequently find out they have lost part of their health insurance benefits. To resolve the issue, HHS should require states to cover former foster care children who were enrolled in a state Medicaid program at some point while in foster care and in foster care on the on the date of attaining 18 years of age (or a higher age elected by the State) or when they aged out.

§ 435.980 and 457.330 - Certified Application Counselors

CSH echoes comments by the National Health Care for the Homeless Council in anticipating that a broad range of professionals, community health workers and others will become involved in efforts to enroll difficult-to-reach populations. Many supportive housing service providers already employ workers skilled at accessing benefits for eligible residents. CMS articulates their goal as ensuring the “quality and privacy and security of the assistance” provided in some states by Certified Application Counselors (CAC) is welcome and appropriate. The proposal’s recognition that less formal assistance, not involving access to the dedicated

¹ “Child Welfare and the Affordable Care Act: Key Provisions for Foster Care Children and Youth,” Center for Children and Families, June 2012.

web portals, will also occur is likewise welcome and appropriate. Where a certification process exists, the rule should help ensure that trainings are widely available and not burdensome. Among other measures, the rule should—

- Encourage states to learn from and connect CAC training to other benefit programs, such as the SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative, TANF, and other similar programs. Often, the benefit specialist is one employee and aligning trainings, applications, and other processes could save time and administrative costs;
- Facilitate training and certification by making them free of charge;
- Ensure CACs have access to a dedicated call center to resolve problems with the system or troubleshoot specific case concerns;
- Permit training to be provided in a web-based format to maximize accessibility;
- Increase the potential workforce by allowing persons without threshold academic credentials or professional licenses, such as community health workers, peer counselors, outreach workers, and case managers to serve as CACs;
- Allow persons already trained in HIPAA confidentiality rules be exempted from duplicative training; and
- Facilitate CACs to track population-specific data to determine the needs of population(s) served, based on demographic characteristics such as age, sex, disability, language(s), race/ethnicity, religion, education level, sexual orientation, and gender identity, as well as socioeconomic status, including **housing status**.

§ 435.952, 435.407 and 435.952 – Verification and Documentation

CSH supports these provisions, as they allow flexibility in producing documentation. For those experiencing homelessness and those displaced by disasters, this flexibility is particular critical. CSH appreciates that CMS recognizes the problems inherent in serving these populations.

While we welcome the requirement for states to provide individuals with assistance in obtaining documentation (p. 94), we request clarification regarding the type(s) of state assistance envisioned here, and how community-based organizations assisting these clients can maximize such assistance. A requirement that states pay or waive the cost of obtaining documents from federal government agencies and other states, is an example of state assistance that would achieve the CMS goal of increasing access to Medicaid among those who have difficulties otherwise accessing Medicaid. Indeed, this tool has proven successful in promoting Medicaid enrollment among the limited number of residents whose eligibility cannot be easily established through the Social Security Administration's (SSA) records or other computerized records. Based on our local service provider experiences with malfunctioning state systems, we also recommend CMS establish language and opportunities for federal assistance that requires and assists states in ensuring that their systems of providing necessary documentation are in good working order and are able to access the federal hub in a timely, accurate manner.

§ 435.1110 – Presumptive eligibility determined by hospitals

CSH supports hospitals' ability to presume eligibility for those anticipated to be Medicaid eligible. Hospitals and emergency rooms are a major point of entry for many poor and unstably housed persons. , All necessary documents for determining Medicaid eligibility should be completed prior to discharge. This requirement will help patients access follow up care and prevent providers from duplicating hospital staff efforts. Hence, we recommend that CMS require all presumptive disability determinations by hospitals be

accompanied by regular Medicaid applications completed prior to hospital discharge. Hospitals should not be held responsible for the ultimate success of the application, but should ensure the applicant properly completes the application prior to discharge.

§ 440.315 – Essential Health Benefits in Alternative Health Plans (Expanding Exempt Populations)

The proposed regulations clarify that people who are include among “medically frail” or have “special needs” are entitled to opt-out of Alternative Health Plans (AHPs) to access traditional Medicaid benefits. Medically frail and special needs populations include people, “with disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness), individuals with serious and complex medical conditions, individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, or individuals with a disability determination based on Social Security criteria or in States that apply more restrictive criteria than the Supplemental Security Income program, the State plan criteria.”

CSH agrees with our partner organizations that people with substance use disorders (SUD) should be included in the definition of people who are medically frail for purposes of expanding access to full-scope Medicaid benefits. Individuals with SUD have similar health needs as those with the other complex preventable and treatable health conditions identified in the proposed medically frail definition, and they require access to the same benefits to improve their health outcomes. People with substance use disorders are more likely to experience chronic medical conditions, face more frequent and more severe complications resulting from their health conditions, and incur significantly higher health costs than people without SUD. Further, as the Substance Abuse and Mental Health Services Administration statistics reflect, adults with behavioral health disorders (including substance use disorders) are twice as likely to be poor than adults without these conditions, and much less likely to receive treatment for their chronic physical or mental health conditions than others without SUD. For these reasons, individuals with SUD often need services that benchmark coverage is less likely to provide, but that Medicaid programs typically cover, including family supports, home and community based services, case management, and transportation.

In addition, the benchmark coverage may impose treatment and financial limitations that may continue to be a barrier to fully accessing appropriate SUD treatment. We are particularly concerned about benchmark coverage in states that may choose the weakest available benchmark plan option for their alternative benefit plans in an effort to limit perceived financial risk for the State or to avoid political risk. Indeed, several states have selected the weakest, least comprehensive benchmark plan for their small group and individual market essential health benefits (EHB). We know from current beneficiaries’ experience that beneficiaries living in states that offer fewer benefits suffer from placement in clinically inappropriate levels of care, poorer outcomes, and more costs to federal Medicaid costs, as well as costs to other state and local systems. Requiring all states to give beneficiaries with SUD the flexibility to choose coverage that best meets their individual needs would improve the health outcomes among this population.

We strongly urge CMS to expand the definition of medically frail to include individuals with SUD in the final rule.

§ 440.330 – Flexibility in Benchmark Health Benefits

CSH commends HHS for clarifying the authority at subparagraph (d) for states to provide a wide range of benefits in developing Secretary-approved coverage. We believe this authority promotes goals of facilitating

state flexibility, helping states design specialized benefits packages, and most importantly, providing states with the ability to align traditional and benchmark benefits.

In particular, we support HHS' inclusion of various options for long term services and supports and care coordination support. These services are essential for supportive housing residents to remain stably housed. We urge HHS to clarify that these benefits are available through a Secretary-approved process, irrespective of whether they have otherwise been implemented in a particular state Medicaid plan. For example, a state may want to design a Medicaid benchmark to target a vulnerable population (e.g., individuals who are frequent users of health systems, those moving out of institutions or those with mental health needs) and include a particularly relevant home or tenancy support service that is not otherwise available in the state's Medicaid program. States should be allowed to develop this proposed service package and submit it to the Secretary for consideration.

§ 447.51, 447.52, 447.53, 447.54, 447.55 and 447.56 – Premiums and Cost Sharing

Overall, CSH is very concerned about new premiums and cost sharing requirements for Medicaid populations, particularly among populations who have complex conditions and may be frequent users of health services. These vulnerable populations already face too many barriers to receiving any appropriate care, let alone high quality health care; a requirement for an individual to pay costs of care would only further exacerbate these barriers. People who are homeless or who are unstably housed do not have any resources to pay for their health care. They spend every dollar to access shelter (which often is not free), find food, or meet other basic needs, such as laundry, personal care facilities, and other needs many Americans take for granted. Some have no source of income whatsoever and live on the streets with severe food insecurities. If CMS allows states to impose costs to pay for basic health care necessary for these individuals to survive, many beneficiaries will further delay care. In essence, these rules promote delayed care, which will lead to some presenting to acute care facilities in need of crisis care and others dying when unable to access care. Cost sharing is far more expensive to the health care system and will result in poorer patient outcomes. The following points detail CSH's concerns with these provisions.

§ 447.51 Cost Sharing Definitions

HHS should revise the definition of *alternative non-emergency service provider* applicable to proposed regulation § 447.54. It is important for the regulation to require these providers to be actually available and able to provide the necessary diagnostic and/or treatment services for which the Medicaid beneficiary has gone to the emergency department (ED) to obtain. Otherwise, individuals are being penalized for making a medical choice which really was no choice at all. Often patients choose emergency room care because local providers are not available either because of workforce shortages or lack of appointment space. We join NHELP and recommend using the definition contained in *Dear State Medicaid Director* (Aug. 15, 2007) (SMDL #07-010) as a guide.

§ 447.52 Cost Sharing

The proposed regulations for outpatient services replace the current tiered copayments with a single copayment based on the individual's income. HHS proposes to set the copayment for the below poverty population at \$4.00—ten cents above the current FY 2013 maximum copayment amount. This is simply too high. Although the 5% aggregate cap does ameliorate the burden for some of beneficiaries, that is not enough.

CSH is concerned about the potential cumulative effect that the increased cost-sharing across different service categories (outpatient, prescription drugs, and the possibility of cost sharing for HCBS) could have on people with disabilities and multiple chronic conditions. Numerous studies have shown that even nominal cost-sharing obligations for this population can deter people from accessing the care and treatment that they need to stay healthy.² For people with complex medical needs, the failure to get any needed care can have a cascading effect on the persons health and result in significant increases in health care cost and utilization in the long-run as a result.

Also, CSH has concerns regarding possible denial of service for non-payment, referenced on page 385 – 386 of the proposed regulation. The proposed rule states that a provider may require an individual to pay cost sharing as a condition for receiving the item or service if the person has income above 100 percent of FPL. The regulation does not state how the provider would make this determination, especially in emergency situations. In addition, determining ability to pay in a crisis situation is also difficult and could be demeaning to the patient and delay care. CSH recommends CMS re-evaluate this provision and state very clearly that no provider may deny service based on inability to pay cost sharing.

While we have major concerns, there are provisions we support. CSH supports reducing the co-pay for inpatient services to \$4 for the first day from up-to 50% of the cost for the first day of care. People are not admitted to facilities for inpatient services without a doctor's determination that such services are medically required. The current cost-sharing is likely deterring some people with disabilities and chronic conditions from getting needed inpatient services, as 50% of the cost of the first day of services could be devastating to people whose incomes are under 100% of the federal poverty line. We encourage HHS to include this change in cost-sharing for inpatient stays in the final rule.

CSH is also pleased that the proposed rule provides states with the option of exempting individuals who are required to spend all but a minimal amount of income for personal needs receiving home and community based services from cost sharing in 42 CFR §447.56. Extending this exemption to people receiving services and supports in the community is consistent with and supportive of the efforts to rebalance away from institutions and toward community living as required by the Olmsted decision.

§ 447.53 Cost sharing for drugs

This section allows states to establish cost sharing for preferred and non-preferred drugs. Individuals with incomes at or below 150% FPL could be charged up to \$4 copays for “preferred” drugs and \$8 copays for “non-preferred” drugs. By contrast, researchers have repeatedly concluded that even low prescription drug copayments cause very low income people not to fill the prescriptions their doctors have given them to treat their health conditions. A study in Minnesota found that when the State imposed tiered copayments of \$1 for generic drugs and \$3 for brand name drugs—far below those in the proposed regulations—slightly more than half of Medicaid patients using a public hospital reported being unable to fill prescriptions because of cost sharing. About one-third of those who went without prescription drugs had more serious

² See, e.g., S. Artiga & M. O'Malley, “Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences,” Kaiser Commission on Medicaid and the Uninsured (May 2005), available at <http://www.kff.org/medicaid/7322.cfm>; Daniel Hartung et al., Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-Service Medicaid Population, 46 Med. Care 565 (2008) and L. Ku & V. Wachino, “The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings,” Center on Budget and Policy Priorities (July 7, 2005), available at <http://www.cbpp.org/files/5-31-05health2.pdf>.

health problems, like strokes, diabetes problems or asthma attacks, and required expensive emergency room care or hospital admission³.

The proposed \$4 preferred drug/\$8 non-preferred drug copayment ignores reality: Individuals cannot be incentivized to simply “prefer” the preferred drug, as is accomplished with some success with middle class consumers. At these income levels and with those high co-pay differentials, Medicaid enrollees are not really given any meaningful choice – they simply will go without the “non-preferred” drug even if it really is necessary and would work far more effectively than a preferred drug.

§ 447.54 Cost sharing for services furnished in a hospital emergency department

The proposed regulation allows states to impose up to an \$8 copayment on individuals with incomes at or below 150% FPL (i.e. twice the currently proposed \$4 copayment) and unlimited copays on individuals with incomes above 150% of FPL.

These copayment levels could be detrimental to frequent users of emergency rooms. Prior to housing, many supportive housing residents, particularly those who experienced chronic homelessness visited ERs 1 or more times a week. This is due to being unable to manage chronic conditions and the harshness of life on the street. Their frequent use is not the patients fault and is due to lack of housing and general instability. Rather than sharing in the costs of an ineffective, inefficient system, resources should be used to improve comprehensive care for the patient and address the reasons why they are visiting the emergency room, i.e. lack of housing, provider shortages, etc. Therefore, CSH recommends no copayments for emergency room visits.

§ 447.55 Premiums

The statute states that CMS is reviewing the possibility of allowing states to impose a maximum \$20 premium for medically needy individuals whose income is under 150 of FPL. CSH strongly urges CMS to reconsider this review. Twenty dollars may seem small but can add up for vulnerable people and become another barrier to care.

§ 447.56 Limitations on premiums and cost sharing

CSH joins NHELP, the Consortium for Citizens with Disabilities and others in being deeply troubled by new limitations on the application of a 5% aggregate cap on cost-sharing for Medicaid beneficiaries. Whereas current rules at § 447.78(a) and (b) apply this cap broadly, the proposed rule selectively applies this cap. The omission of a 5% aggregate cap for Medicaid beneficiaries below 100% of FPL violates statutory requirements at 42 U.S.C. § 1396o-1(a)(2)(B). The May 2010 final rule that implemented the § 447.78 notes that §§ 1396o and 1396o-1 should not be read in isolation, for to do so “would frustrate the statutory purpose and permit a State to effectively impose aggregate cost sharing far in excess of 5 percent of family income by using the two statutory cost sharing options cumulatively.” (75 Fed. Reg. 30253). This is exactly what the proposed rule would do for any group not listed in § 447.56(f)(2). In HHS’ own words:

Such a result would be an inadequate beneficiary protection and would not achieve the statutory purpose of the aggregate limit. The clear statutory purpose is to limit family cost sharing obligations

³ Melody Mendiola et al. “Medicaid Patients Perceive Copays as a Barrier to Medication Compliance,” Hennepin County Medical Center, Minneapolis, MN, presented at the Society of General Internal Medicine national conference, May 2005 and American College of Physicians Minnesota chapter conference, Nov. 2004.

to 5 percent of family income and that purpose can be achieved only if the aggregate limit applies to all cost sharing imposed under the State plan for all family members, including cost sharing imposed under section 1916. (75 Fed. Reg. 30253)

Such changes significantly erode one of the most critical beneficiary protections and *add* administrative complexity because states will have to employ more complex tracking systems. HHS also pledges in the preamble that the proposed rules will “greatly simplify and streamline the cost sharing regulation ‘in a manner that is consistent with simplicity of administration and the best interests of the recipients,’ in accordance with section 1902(a)(19) of the Act.” (78 Fed. Reg. 4595.) The changes proposed here are most certainly not consistent with § 1902(a)(19), which was *correctly* invoked to explain the implementation of § 447.78. HHS has provided no rationale to explain this major regulatory change.

Even if HHS elects to continue with a selective application of the 5% aggregate cap, it is imperative for the regulations to apply the cap to all individuals below 100% of FPL. This omission clearly violates 42 U.S.C. § 1396o-1(a)(2)(B), which applies the cap to all individuals covered under § 1396o. We see no alternative interpretation, certainly not one in the best interests of the beneficiary, that would permit a State to apply cost sharing to the very poorest of the poor – individuals below 100% of FPL – without subjecting that cost-sharing to a 5% aggregate cap. As a matter of policy, that the copayment may not be mandatory for them to pay is irrelevant to the effect that unlimited copayments will actually have on these poor who are trying to pay the copay charge.

Thank you for the opportunity to comment and we look forward to working with CMS as the final rule is created.

Sincerely,

A handwritten signature in black ink that reads "Deborah De Santis". The signature is written in a cursive, flowing style.

Deborah De Santis
President, CEO
Corporation for Supportive Housing