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March 20, 2008

Mr. Dennis G. Smith,
Director – Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS -2232-P, State Flexibility for Medicaid Benefit Packages Proposed Rule, 73 Federal Register, February 22, 2008

Dear Mr. Smith:

The American Health Care Association (AHCA) and the National Center For Assisted Living (NCAL) are committed to performance excellence and Quality First, a covenant for healthy, affordable, and ethical long term care. AHCA/NCAL represent nearly 11,000 non-profit and for-profit providers dedicated to continuous improvement in the delivery of professional and compassionate care for our nation's frail, elderly and disabled citizens who live in nursing facilities, assisted living residences, subacute centers and homes for persons with mental retardation and developmental disabilities. Because we serve these vulnerable populations who are often Medicaid beneficiaries, we are extremely concerned about the implementation of section 6044 of the Deficit Reduction Act (DRA) of 2005. We appreciate the opportunity to offer our comments on the proposed rule.

Executive Summary

Section 6044 of the DRA allows states to amend their Medicaid state plans to provide for the use of benefit packages other than the standard Medicaid benefit package, namely benchmark benefit packages or benchmark-equivalent packages, for certain populations. The statute also specifies those exempt populations that may not be included or mandated in the benchmark coverages. To be eligible for funds under this new provision, states must submit a state plan amendment, which must be approved by the Secretary of Health and Human Services.

This proposed rule would implement the benchmark benefits provision and is consistent with guidance that the Centers for Medicare & Medicaid Services (CMS) issued previously. Specifically, on March 31, 2006 CMS released a State Medicaid Director letter on the implementation of section 6044. Language in the proposed rule closely mirrors the language in the State Medicaid Director letter.

AHCA/NCAL is limiting its comments to issues relating to the vulnerable exempt populations and optional enrollment. While the proposed regulation, and the State Medicaid Letter before it, appear to be clear regarding the absolutely voluntary nature of the enrollment, this aspect has been ignored in practice by states that have implemented benchmark benefits packages. Based on the behavior and approach of these states, we believe that CMS must strengthen its proposal to assure compliance with the statute. We provide below our recommendations and a discussion of our concerns.

THE AMERICAN HEALTH CARE ASSOCIATION IS COMMITTED TO PERFORMANCE EXCELLENCE AND QUALITY FIRST, A COVENANT FOR HEALTHY, AFFORDABLE AND ETHICAL LONG TERM CARE. AHCA REPRESENTS MORE THAN 10,000 NON-PROFIT AND FOR-PROFIT PROVIDERS DEDICATED TO CONTINUOUS IMPROVEMENT IN THE DELIVERY OF PROFESSIONAL AND COMPASSIONATE CARE FOR OUR NATION'S FRAIL, ELDERLY AND DISABLED CITIZENS WHO LIVE IN NURSING FACILITIES, ASSISTED LIVING RESIDENCES, SUBACUTE CENTERS AND HOMES FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES.

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AHCA/NCAL Recommendations

- *AHCA/NCAL recommends that CMS require states to offer exempt populations the option to enroll into the benchmark package, making clear that enrollment is voluntary and that even after voluntary enrollment, an exempt beneficiary may disenroll out of the benchmark package.*
- *AHCA/NCAL recommends that CMS enhance the proposed rule to include a section on CMS oversight. Such an oversight section should contain a requirement that CMS approve state informational materials (both print and web) that provide comparative information, information on choice, and marketing limits to avoid overzealous Medicare Advantage marketing.*
- *AHCA/NCAL recommends that CMS include in its rule an evaluation of the impact on beneficiaries of the benchmark benefit packages.*

Discussion

Proposed Rule 42 CFR 440.305, 315, and 320 -- Exempt Individuals and Optional Enrollment

CMS makes clear at the outset of the Notice of Proposed Rulemaking its belief that “Congress intended to provide States unprecedented flexibility within Medicaid State Plans to provide health benefits coverage.” While we do not question that states are provided unprecedented flexibility, we think it is equally important to recognize that Congress did not extend this unprecedented flexibility to vulnerable populations such as individuals residing in long term care facilities. Congress unequivocally and specifically exempted 11 groups of beneficiaries from the benchmark coverage provision, including vulnerable populations such as individuals residing in long term care facilities, as follows:

- *A recipient qualifying for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income (SSI) benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act;*
- *A recipient entitled to benefits under any part of Medicare;*
- *A terminally ill recipient receiving benefits for hospice care under title XIX;*
- *A recipient who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs;*
- *A recipient who is medically frail or otherwise an individual with special medical needs (as described by the Secretary);*
- *A recipient qualifying based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.*

Clearly, under Section 6044 of the DRA, states cannot require beneficiaries who are elderly or disabled and receiving long term care services to enroll in benchmark benefits packages. In the proposed rule and in previously issued guidance, CMS allows states to enroll exempt beneficiaries in benchmark packages on a voluntary basis. CMS makes clear in its proposed rule that voluntary means that beneficiaries must be **offered** enrollment. According to both the proposed rule and earlier guidance, when a state decides to offer exempt beneficiaries the choice of enrolling in a benchmark package, it must let them know how the benchmark package differs from the coverage they would receive under standard Medicaid. The state also must inform the

individual that the enrollment is voluntary -- that is, beneficiaries may accept or decline the offer -- and, further, that the beneficiary may opt out at any time.

While the proposed regulation appears to be clear regarding the absolutely voluntary nature of the enrollment, this aspect has been ignored in practice by at least two states.

- **Kentucky** -- On May 3, 2006, Kentucky received federal approval for its plan to offer benchmark benefits. The state established four benchmark benefit packages, two of which--Optimum Choices and Comprehensive Choices--are for elderly persons and people with disabilities who need long term care services. Thus, the two benefit packages focus entirely on beneficiaries who are exempt from mandatory enrollment in benchmark benefits. On May 15, 2006, Kentucky sent letters to Medicaid beneficiaries informing them of the changes to its program. Some elderly beneficiaries and people with disabilities received letters assigning them to Comprehensive Choices or Optimum Choices. The letters stated, "you may opt-out and you will be placed into the Global Choices plan, but you will be required to pay higher co-payments." The letters did not provide the required comparison and discouraged the exempt beneficiaries from exercising their right to opt out by warning of potential higher co-payments.
- **Idaho** -- On May 19, 2006, Idaho received federal approval for its plan to offer benchmark benefits. The state established three new benefit packages, two of which—Enhanced Benchmark Benefit Package for Individuals with Disabilities (and Elders) and Benchmark Benefit Package for Dual Eligibles—focus on beneficiaries who are exempt from mandatory enrollment in benchmark benefit packages. Idaho's information to health care providers on the enhanced package did not mention that enrollment in the package is voluntary and that beneficiaries have a choice of remaining in the regular Medicaid program. It stated that participants who are found eligible for Medicaid will be enrolled in either the basic or enhanced benefit package. The "Frequently Asked Questions for Participants" section of the state's website likewise did not explain that enrollment is voluntary and that beneficiaries have a choice. It told Medicaid applicants that they will be placed in either the basic or enhanced package, depending on their health needs. Current beneficiaries were told that they will be enrolled in either the basic or enhanced benefit package at their renewal date. Also, Idaho eliminated a number of previously offered benefits in its traditional Medicaid program benefits, thus making that choice a less realistic option.

In addition, Idaho's Benchmark Benefit Package for Dual Eligibles requires enrollment in a Medicare Advantage plan to receive the coordinated benefit package. In this case, there is voluntary enrollment; however, Medicare Advantage marketing to this vulnerable population has been relentless. Beneficiaries receive a monthly letter until they either sign up for the program or place themselves on a "do not call" list. Marketers arrive uninvited in assisted living facilities in efforts to solicit more enrollments.

Based on the behavior and approach of these states, we believe that CMS must enforce the voluntary aspect of enrollment of exempt individuals. Therefore, we provide the following recommendation:

- *AHCA/NCAL recommends that CMS require states to **offer** exempt populations the option to enroll into the benchmark package, making clear that enrollment is voluntary and that even after voluntary enrollment, an exempt beneficiary may disenroll out of the benchmark package.*

Further, AHCA/NCAL believes that without oversight and additional requirements, the protections in the proposed rule, e.g., inform exempt beneficiaries of how the benchmark benefit packages and standard Medicaid differ and its voluntary nature, would not realistically meet the statutory exemption requirement. The language in the proposed rule closely mirrors the language in the March 31, 2006 CMS letter to State Medicaid Directors, which provides guidance to states on implementing the Benchmark Benefits provision. However, as we have seen above, utilizing that guidance, two states implemented benchmark benefits packages and included exempt populations without offering them a true choice or the information needed to make a choice.

This should be a warning to CMS that stronger regulation is necessary to achieve compliance with the statutory exemption. No state should be allowed to undercut the protection that Congress sought to provide for these groups of beneficiaries when it exempted them from the benchmark benefit packages.

We note that in the early implementation states of Kentucky and Idaho, CMS appears not to be enforcing its own requirements that exempt beneficiaries are offered choices and comparative information. CMS must provide oversight, which should include CMS approval of state informational materials (both print and web) providing comparative information as well as information on choice. CMS should include oversight and approval of marketing limits to avoid, for example, the overzealous Medicare Advantage marketing. Thus,

- *AHCA/NCAL recommends that CMS enhance the proposed rule to include a section on CMS oversight. Such an oversight section should contain a requirement that CMS approve state informational materials (both print and web) that provide comparative information, information on choice, and marketing limits to avoid overzealous Medicare Advantage marketing.*

Finally, CMS, by allowing states to enroll exempt beneficiaries in benchmark benefit packages, has weakened the protection that Congress intended for the exempt groups. Currently, CMS does not require states to evaluate the impact on beneficiaries of the benchmark benefit packages. We believe that such evaluation is an absolute necessity when dealing with vulnerable populations. Thus,

- *AHCA/NCAL recommends that CMS include in its rule an evaluation of the impact on beneficiaries of the benchmark benefit packages.*

Conclusion

This rule provides CMS with the opportunity to lessen the risk that exempt beneficiaries will not be given the information they need to make informed choices. Kentucky and Idaho serve as case studies that strongly suggest that, without stronger action by CMS, the risk is significant.

Sincerely,



Bruce Yarwood
President & CEO