

October 19, 2001

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-2104-P
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: CMS-2104-P
Medicaid Managed Care; Proposed Rule**

Dear Sir or Madam:

The National Health Law Program is a private, non-profit organization which advocates on behalf of low-

The Delay of the Final Rules

On January 19, 2001, the Centers for Medicare and Medicaid Services (CMS) issued final regulations in

CMS' notice of "further delay of effective date" issued in August, and the previous delays, violate the Ad

Informing

The proposed rule omits Proposed § 438.10(b)(2)(ii)(E), (f)(6)(iv). This omission eliminates any discussion of the proposed rule's impact on the ability of health plans to provide information to enrollees about their reproductive health care options.

We strongly urge at the least that health plans be required to provide a referral to a state-sponsored toll-free number for reproductive health care information.

Also of concern is the scope of information provided to the enrollee prior to enrollment. Whereas the January rules required that the enrollee be provided with information about the plan's reproductive health care benefits, the proposed rule omits this requirement.

In addition, the proposed rules further delay when potential enrollees can get this information by requiring that the enrollee be provided with information about the plan's reproductive health care benefits only after enrollment.

As under the January rules, the proposed rules require that soon after enrollment, certain information be provided to the enrollee. This information includes the plan's reproductive health care benefits, the plan's policies on reproductive health care, and the plan's policies on the availability of reproductive health care services.

The January rules also required that the information be provided annually thereafter. Under the proposed rules, the information is required to be provided only once, at the time of enrollment.

In the discussion regarding the requirement that enrollees be told of any limits on freedom of choice among providers, the proposed rules state that the enrollee must be informed of any such limits. However, the proposed rules do not specify what information must be provided to the enrollee.

The proposed rules add § 438.10(f) to require States to notify enrollees of their disenrollment rights at least annually. This requirement is not included in the January rules.

Enrollee-Provider Communication

A significant omission is a requirement that health plans that exclude coverage of certain counseling or services must provide information to the enrollee about the exclusion. This requirement is not included in the January rules.

Disenrollment

The proposed rules include certain reasons for disenrollment for cause that were included in the January rules. These reasons include: (1) the enrollee's failure to pay premiums; (2) the enrollee's failure to provide accurate information; (3) the enrollee's failure to provide information about their reproductive health care needs; (4) the enrollee's failure to provide information about their reproductive health care preferences; (5) the enrollee's failure to provide information about their reproductive health care history; (6) the enrollee's failure to provide information about their reproductive health care goals; (7) the enrollee's failure to provide information about their reproductive health care concerns; (8) the enrollee's failure to provide information about their reproductive health care questions; (9) the enrollee's failure to provide information about their reproductive health care needs, preferences, history, goals, concerns, questions, or any combination thereof; and (10) the enrollee's failure to provide information about their reproductive health care needs, preferences, history, goals, concerns, questions, or any combination thereof, as determined by the health plan.

- (1) the plan does not, because of moral or religious objections, cover the service the enrollee seeks;
- (2) the enrollee needs related services (for example a cesarean section and tubal ligation) to be performed;
- (3) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the plan.

See proposed § 438.56(d)(2); January § 438.56(d)(2).

Free Choice of Provider

We support the clarifying language that, under the BBA, beneficiaries have the right to a free choice of provider.

Out-of-Network Access

The proposed rule includes a requirement in § 438.206(b)(4) that if the network cannot provide the necessary services, the plan must cover out-of-network services.

In addition, whereas the proposed rule requires states to directly ensure that health plans meet the requirements, the January rule requires states to ensure that health plans meet the requirements through their contracts.

The proposed rule includes a requirement that the out-of-network services do not result in greater costs than in-network services.

For beneficiaries in rural areas, the January rule would have allowed individuals to access out-of-network services if the network cannot provide the necessary services.

Under the January rules, out-of-plan access also was available in cases of a medical emergency. CMS stated that the rule would apply to all enrollees, regardless of whether they are in a rural area.

The proposed rules also maintain the right of rural enrollees to access services out-of-network where (1)

However, we are concerned about the confusing and seemingly contradictory discussion in the preamble

Availability of Services

Section 438.206 of the proposed rule requires each State to § 438.206 that with covered services are available

Second, the proposed rule does not include the proposed § 438.206 that with services under the state plan

Implementation of this provision would avoid confusion and delay in assisting enrollees to access these

Specific delivery network requirements also were proposed. The proposed § 438.203(b) rules do not require States to

Direct Access to Women's Health Specialists

The proposed rule includes language regarding direct access to women's health specialists for female

What is not included is a definition of what constitutes "routine and preventive services" which female

Screening, Assessment, and Treatment Planning

Identification : The January rules listed individuals who must be identified

The proposed rule would require only that "individuals with special health care needs, as specified by the

Screenings and Assessments In the January rule, CMS differentiated between the term

The proposed rule makes no distinction between screenings and assessments. The fact that CMS would

Time frames : Under the January rules, each health plan would have 1

For any screened enrollee identified as being pregnant or having special needs, the health plan would h

None of these time frames ~~is~~ **comparable** included in the proposed rule § 438.208(c) with January

Treatment Planning: January § 438.208(f) set forth rules for health plans to develop and implement t

The proposed rule does not include any of these requirements and instead only requires States to § 438.208

In response to concerns about individuals with ongoing health care needs, including pregnant women, w

The proposed rules make the requirement to develop treatment plans of little or no value. They give hea

Liability and Cost Sharing

The proposed rules include language clarifying that enrollees may not be held liable for covered services.

A separate cost sharing provision makes clear that a January 1, 2018, proposed rule regarding the proposed

In addition, services that are accessed out-of-network due to the health plan's inability to provide needed

Specification of Contract Benefits

Section 438.210(a) of the January 1, 2018, proposed rule requires contracts to clearly specify, however, services like PCMs are

Prior Authorization Request Processing

The proposed rule fails to include any requirements that January 1, 2018, proposed rule contractors have in place

Limitations on Payments to Providers

In order for a State to pay providers for family planning and other services that are included in the plan or

Confidentiality

The proposed rule requires that January 1, 2018, proposed rule "through language that states" that for medical records and

Conclusion

The proposed regulations, if implemented, would significantly weaken protections and responsibility for c

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Please contact Lourdes Rivera, 310-204-6010 x 3011, rivera@healthlaw.org, or Mara Youdelman, 202-2

Submitted on behalf of

The Alan Guttmacher Institute
American Civil Liberties Union
American Federation of State, County and Municipal Employees
Birthing Project USA
California Pan Ethnic Health Network
California Women's Law Center
Citizen Action of New York
Community Healthcare Network (New York, NY)
Family Planning Advocates of New York State
Gay Men's Health Crisis (New York, NY)
Greater Upstate Law Project, Inc.
Medical and Health Research Association of New York City, Inc.
Merger Watch
Mexican American Legal Defense and Educational Fund
Michigan Association for Children with Emotional Disorders
Michigan Association for Infant Mental Health
National Abortion and Reproductive Rights Action League, NY Affiliate (NARAL/NY)
National Center for Youth Law
National Health Law Program

National Latina Health Organization
National Women's Law Center
Northwest Health Law Advocates (Seattle, WA)
Planned Parenthood of New York City
Public Justice Center (Baltimore, MD)
Virginia Poverty Law Center
Women's Health and Family Planning Association of Texas
Women's Health Specialists (Chico, CA)

1. The BBA amended the Medicaid statute to permit 42 USC § 1396n(a)(1)(A) as amended. See [H.R. 1633, 116th Cong.](#)
2. See Jane Perkins & Kristin Olson, [National Latina Health Law Center, "Reproductive Health and Family Planning: A Call to Action,"](#) 116th Cong. (2019).