

July 23, 2010

Cindy Mann
Deputy Administrator, Centers for Medicare and Medicaid Services
Director, Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare and Medicaid Services
Baltimore, MD

RE: Comments on Washington State Waiver Application

Dear Ms. Mann,

Thank you very much for providing the opportunity to discuss the pending Washington section 1115 Waiver on July 2. We are writing to follow up with additional information and to comment on the waiver proposal that the state submitted on July 7.

Follow-up information

During our conversation, you asked under what circumstances Basic Health enrollees are actually required to pay the deductible to a provider. We indicated that hospitals generally don't charge patients these deductibles due to hospital charity care laws and requirements. However, we want to mention two important caveats. First, not every Basic Health patient applies for charity care. Second, some providers who perform services, such as surgeons, anesthesiologists, and radiologists, are not hospital-based and therefore are not subject to the hospital charity care requirements. They may bill enrollees for the deductibles. We know of no data on how often Basic Health enrollees are billed for deductibles.

You also expressed interest in data on the impact of recent premium increases on Basic Health disenrollment patterns. We had recently received some information from the Health Care Authority. We understand that the Medicaid Purchasing Administration is providing this information to you and we are in the process of confirming this.

Comments on the Waiver Proposal

We have reviewed the Washington State 1115 Demonstration Waiver Proposal: Transitional Bridge for Low-Income Adults, except for Appendix 2 which is not yet available. As we indicated in our conference call, we strongly support this request and believe this waiver is necessary to preserve coverage for 69,000 vulnerable and low-income Washingtonians.

We are very pleased that the state is now proposing to eliminate the Disability Lifeline time limit and to roll back premiums to \$17 per month for those on Basic Health with incomes between 0 and 65% of the federal poverty guidelines. We urge you to approve the waiver request, including these terms, as soon as possible.

In these comments, we address points in the waiver application that are new or changed from the original concept paper. We also offer additional information and clarification of differences

between Basic Health and Medicaid that are not mentioned in the waiver proposal, primarily regarding agency procedural responsibilities and client rights, which should be considered in the context of this waiver.

1. Screening Current Basic Health Enrollees for Medicaid

The proposal would screen new Basic Health applicants for non-waiver Medicaid eligibility, but would not screen existing BH enrollees, although it is estimated that thousands may qualify as parents, caretaker relatives and children within the income guidelines of the Medicaid program. The proposal notes that it is unprecedented for CMS to allow a waiver that does not require screening for a more favorable program.

We believe that the state should also be responsible for screening its existing BH population for full Medicaid/DL eligibility. It is important for the agency to ensure that a person is offered the most favorable program for which they are eligible, so they are not subject to the costs and coverage limitations of BH unnecessarily. The person should be able to seamlessly transition to that program once determined eligible. We believe that this can be done in a manner that is not excessively burdensome to the state and preserves program integrity.

The state has expressed concerns about the administrative burden of screening existing enrollees, as well as the potential adverse impact on the risk pool. We are also aware of the potential that any Basic Health enrollee slot that is freed up (as a result of transitioning eligible individuals to Medicaid) may go unfilled. Due to the state's worsening revenue forecast, the financing for Medicaid and Basic Health over the next few years may be vulnerable. It would be important to ensure the integrity of Basic Health if enrollees are shifted between programs.

Currently, our patients and clients experience the fallout of a "siloed" system straddling two agencies. The blending of these agencies into a single one, operating a Medicaid waiver program alongside other Medicaid programs, creates an opportunity to finally unify eligibility procedures. Both applicants and existing enrollees should be screened.

2. Capping Disability Lifeline

While the proposal has removed the DL time limit, it requests authority to cap the Disability Lifeline program, if required in the future. While we recognize the fragile fiscal reality of our state, we do not think this authority is consistent with CMS's desire to see stability or forward movement. The DL population is the lowest income and most vulnerable, and should be protected from erosion. Otherwise, the door would be opened for a much more draconian cut than the 2-year time limit: complete exclusion of eligible individuals from the Medicaid waiver.

3. Coverage of Services in the Waiver Programs

While we understand that the waiver is not designed to significantly change BH coverage, we want to be sure that the actual scope of programs is clear. We wish to bring to your attention that Exhibit 10, Comparative Summary of 2010 Public Program Benefits for Adults, while largely correct, deviates somewhat from the benefits provided by state-funded programs in practice.

Basic Health

- Interpreter services are not listed as a Basic Health benefit.¹ When limited English speakers contact the agency, interpreter/translation services are provided. Basic Health applicants and members should receive interpreter/translation services at the same level and with the same contractual requirements as clients in other medical assistance programs.
- Certain services, including home health and some rehabilitative services, are only provided at the discretion of the plan. These discretionary services should be recognized as non-covered unless they become mandatory contract services or there is fee-for-service wraparound coverage.
- Contrary to what is noted in the chart, speech therapy is not covered under Basic Health.

Medical Care Services

Medical Care Services is governed by the Washington Administrative Code (WAC), and there is also a contract with a health plan for the provisions of services through managed care. This contract is subject to change without public notice. We urge CMS to reference the MCS services specified in WAC as of the date of the waiver application as the covered services under the waiver, considering the state's statement on page 22 of the proposal that "At this time, there is no intent to reduce benefits offered to enrollees – our goal is to sustain and if possible improve benefits during the demonstration to support a smooth transition to NHR implementation in 2014."

We were advised by Medicaid staff that that the actuarial estimates of benefit equivalence were not based on Exhibit 10 but on the actuary's knowledge of the programs; we were unable to verify this before submitting these comments.

4. Nonpayment Exclusion Policy of Basic Health

BH excludes a member from the program for 12 months for missing two consecutive premium payments or three nonconsecutive payments in the course of a year. Moreover, when there is a waiting list the former enrollee must go to the very end of the line, so the exclusion is much longer, in reality. We are not aware of any other cost-sharing penalty in a Medicaid waiver that is this punitive. Considering the unaffordability of Basic Health cost-sharing, this penalty creates insurmountable barriers to a person with little income who is trying to maintain coverage.

Considering that most BH enrollees would have no premiums under Medicaid rules, we think the 12-month exclusion should be eliminated. A better model for handling episodes of nonpayment is the state's [Healthcare for Workers with Disabilities \(HWD\)](#) program, a premium-based program for people with incomes up to 220% FPL. In that program, there is a more flexible policy regarding disenrollment for nonpayment, and there is a much shorter exclusion from the

¹ Interpreter services are not listed in the certificate of coverage or specified as a benefit in the plan contracts. The Basic Health contracts between the Health Care Authority and health plans contain the following language: "Contractor shall assure equal access of Covered Services . . . for all Enrollees when oral or written language creates a barrier to such access."

program once premiums are paid up. Thus, if an HWD enrollee misses four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed; then HWD coverage can be approved again. This sensible policy should be applied to BH as well.

5. Procedural changes needed to unify programs in order to prevent gaps in eligibility and enrollment and simplify program administration

As we mentioned in our previous letter, there are a number of key procedural changes that should be made to implement the waiver. The waiver proposal compares substantive eligibility rules of BH and MCS with those of Medicaid but does not discuss some critical differences in the way clients of the program are treated. The areas that are most critical to align, as we discussed, are the application process, redeterminations, notices, appeals, and rulemaking. Although there are other procedural differences between the programs, we recognize that it would be problematic to insist on complete alignment immediately; we hope to work in partnership with the state to adopt a timetable for full coordination of the procedures.

a. Application process

Currently, an individual can apply for Medicaid and MCS (as well as cash and food programs) on the same form, but Basic Health has a completely separate form and process. Each agency has a time limit for its own application process. DSHS is required to process applications within 45 days (60 days for SSI-related Medicaid). BH rules require an application to be reviewed within 30 days.

Regarding the application process we suggest that: (1) the two processes should be streamlined to eliminate duplicate requests for information, and (2) time standards for processing an application for the combined programs should be established. In the waiver proposal, the state includes a simple flowchart (Exhibit 9) that shows a referral loop from Basic Health to Medicaid programs and back again. It is difficult to address the above issues based on this limited information. We would appreciate CMS clarification that under the waiver, BH applicants will have the right to submit a combined application (rather than two separate ones) and to have it processed promptly. A good starting point for developing a combined system is the current application process used for children applying to BH. The family completes a single application that is referred to the Medicaid agency for a determination of Apple Health for Kids eligibility. This could be even more streamlined now that the Medicaid and Basic Health programs are combined under one agency.

In this streamlined application process, we strongly recommend that certain protections used in medical assistance programs be extended to BH applicants. Most importantly, the state should use the DSHS Limited English Proficient (LEP) standards for interpreters and translation, and the DSHS Equal Access standards for people needing other accommodations. These standards were carefully designed to ensure that people, regardless of their language, disability or other needs, have the opportunity to make their needs known.

b. Redetermination

It is the duty of the agency, not the client, to determine which medical assistance program a client qualifies for.² This duty applies not just at the time of application but when eligibility for one program ends. Before terminating assistance, the agency must determine whether the client qualifies for any other medical assistance program. In the meantime, the person remains eligible for coverage and benefits cannot lapse.

The state's waiver proposal does not address redetermination. CMS should clarify that once MCS and BH become Medicaid waiver programs, the state is obligated to redetermine eligibility prior to terminating assistance. Currently, a person being terminated from Medicaid/MCS and returning to BH is required to affirmatively reapply within 30 days or lose their "right of return" to that program. The reapplication requirement should be eliminated. Instead, the agency should inform the enrollee of any information needed to transition between programs, thereby preventing gaps in eligibility or enrollment. For those who do not have this right of return, their name should be automatically placed on the BH waiting list.

In addition, the state should screen enrollees who become ineligible for Basic Health to determine whether they may be transferred to Medicaid or DL.

c. Notices

Basic Health and Medicaid/MCS differ in their ways of notifying clients of planned actions. Medicaid/MCS rules require the state to follow federal standards for advance and adequate notice; Basic Health rules do not (although in practice most notices contain many of these elements). Similarly, Basic Health has no rules requiring notice to clients when a service is denied. To eliminate any ambiguities, the Medicaid requirements should be explicitly adopted for BH. This would give members advance and adequate notice of adverse actions in a uniform manner, regardless of the particular program they are in.

A unified notice system will prevent duplication and confusion for clients who would otherwise receive multiple, inconsistent denial or disenrollment/termination notices. A person should not receive a Medicaid denial and a Basic Health approval notice for the same application; the two should be combined. Notices need to be clear and understandable; it is difficult to imagine how this would happen unless the agencies use a common standard.

d. Appeals

The waiver proposal addresses the unification of the *health plan* appeals process regarding disputes about covered services. However, the state does not propose to change the process for a BH appeal of an *agency* action, such as a disenrollment, suspension, or premium calculation. There are large differences; Basic Health appeals are based on the state's "brief adjudicative procedure" which is much more restricted than the fair hearing process required by federal Medicaid law and state standards used for Medicaid, MCS and other public assistance programs.³ When a person's right to vital public benefits is at stake, this limited review without

² 42 CFR § 435.930(b)

³ Washington Administrative Code, chapter 388-02.

opportunity to appear in person, present witnesses, cross-examine, or have an independent decisionmaker, is inadequate.⁴ Also note that with two different appeal procedures, it would be an administrative nightmare to determine which one is used in many cases. For example, if a person receives a denial notice for both Basic Health and Medicaid, would they need to pursue (and the agency defend) two separate appeals? To avoid this absurd consequence, the Medicaid/MCS fair hearing process should be used for Basic Health appeals also.

Other limitations also make it harder to use the Basic Health appeals process. An appeal must be filed within 30 days (as contrasted with a 90-day period for Medicaid); it must be in writing and include all the facts and supporting documentation, and various other specific elements. Medicaid requires only a general request that can be oral or written. The Medicaid/MCS rules should be applied to BH as well.

We wish to clarify a statement in the waiver proposal. In Exhibit 19, section F (“Grievance Systems”), the state lists the third step in appealing a Basic Health administrative decision as “Independent judicial review by the State Office of Administrative Hearings (OAH) – legal representation at no cost to client if requested in accordance with RCW 34.05.542.” While it is true that after the two levels of internal agency appeals, there is a right to judicial review, this review is performed by a Washington civil court judge, not by the OAH. In addition, there is no right to free legal representation for judicial review appellants in Washington.

e. Rulemaking

Many BH procedures critical to enrollees’ eligibility for coverage and care are not adopted in the rulemaking process. These exist only as internal agency policies and procedures, “FAQs” on the Basic Health website, and a Member Handbook. Without publicly-adopted rules, there is little accountability as policies are subject to change without notice and opportunity for comment. We strongly recommend that Basic Health adopt rules that bring it into conformity with the Administrative Procedures Act rulemaking standards that are observed by the Medicaid and MCS programs.

We urge CMS to quickly grant the requested waiver, incorporating conditions that we discussed in this letter.

Thank you very much for considering our comments. We would be glad to provide further information upon request.

Sincerely,

Northwest Health Law Advocates
Community Health Plan of Washington
Community Health Network of Washington
Community-Minded Enterprises
Fuse

⁴ The Basic Health appeals process for agency determinations, WAC 182-25-105, provides no right to a fair hearing except in cases of disenrollment for nonpayment (and then, only at the second appeal level).

Group Health Cooperative
Health Care for All – Washington
Islamic Civic Engagement Coalition
International Community Health Services
Legal Voice
Puget Sound Alliance for Retired Americans
Solid Ground
Statewide Poverty Action Network
UFCW 21
Washington Association of Community & Migrant Health Centers
Washington CAN!
Washington State Hospital Association
Washington State Medical Association

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