

February 21, 2013

Sarah deLone and Stephanie Kaminsky  
Centers for Medicaid and Medicaid Services  
Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

**RE: File Code CMS-2334-P**

Dear Ms. DeLone and Ms. Kaminsky:

As an organization committed to improving health insurance coverage for adolescents, and with a network of partners that include national organizations and adolescent-based health centers, The National Alliance to Advance Adolescent Health is pleased to submit our comments on the Proposed Rule on Medicaid, Children's Health Insurance Programs, and Exchanges, issued on January 22, 2013, to implement provisions of the Affordable Care Act (ACA) and the Children's Health Insurance Program Reauthorization Act (CHIPRA). The proposed rule calls for important changes to streamline and coordinate Medicaid and CHIP eligibility and enrollment with other health coverage programs under the ACA. It also implements expanded Medicaid coverage for individuals under 26 aging out of foster care and Medicaid optional coverage for family planning services.

We respectfully submit our comments on the proposed rulemaking and offer specific suggestions for strengthening the Rule as it relates to adolescents and young adults.

**I. Medicaid Eligibility Expansion Part II**

**3. Medicaid Eligibility Changes under the Affordable Care Act**

**(a) Former Foster Care Children (Section 435.150)**

We support the language of the proposed rule implementing the new mandatory Medicaid eligibility group for former foster care children under the age of 26 and, in particular, commend HHS for recognizing that former foster care children are a highly mobile population. However, we urge the agency to mandate that states provide Medicaid coverage to former foster care children if they were in foster care and receiving Medicaid in any state at the relevant point in time. Making coverage optional for those who have moved out of state after leaving foster care would not meet Congressional intent to ensure that these young adults, whose health care needs are significantly greater than their peers, have access to adequate, affordable health insurance. As described in a recent study conducted by Mathematica Policy Research for the US Department of Housing and Urban Development,<sup>1</sup> frequent moves are common soon after leaving foster care, often out of state. In fact, their living situation is

typically unstable, with homeless periods very common. Moreover, very few former foster care children remain with their foster family after leaving the child welfare system.<sup>ii</sup> Yet, regardless of where they live, former foster care children are an especially vulnerable population of children and young adults, as evidenced by their significantly higher rates of mental health and substance abuse disorders, chronic medical conditions, and pregnancy.<sup>iii</sup>

### **(c) Family Planning (Section 435.214)**

We strongly support the decision to permit states to provide coverage, without obtaining a waiver, for family planning services to individuals who are not pregnant and have incomes up to the highest level income levels established by the state for pregnant women under the state's Medicaid or CHIP plan. Further, we support codifying the current policy described in the State Health Official Letter of July 2, 2010, which permits states to consider only the income of the individual applying for family planning benefits in determining eligibility. In addition, we support amending the definition of a targeted low income child so that CHIP enrollment is not precluded by the receipt of Medicaid family planning services, which may not be covered under a state's CHIP program.<sup>iv</sup> Access to Medicaid family planning services is critical for older adolescents and has repeatedly been shown to reduce unplanned pregnancies and produce substantial savings for state and federal budgets.<sup>v</sup>

## **10. Children's Health Insurance Program Changes**

### **(a) CHIP Waiting Periods (Section 457.805)**

We applaud HHS' proposal to revise existing regulations so as to limit states' waiting periods for CHIP eligibility to a maximum of 90 days and also applaud its proposal to mandate that the waiting period be waived under specific circumstances, including when the cost of discontinued coverage exceeds 5 percent of household income, when the cost of family coverage that includes the child exceeds 9.5 percent of the household income, when the employer stops offering coverage of dependents, when there is a change in employment, including loss of access to employer-sponsored insurance, when the child has special health care needs, and when the child loses coverage due to the death or divorce of a parent. We are especially supportive of HHS' proposal to prohibit states from applying waiting period requirements to children in families with incomes above 200 or 250% of federal poverty level and its stated intention to eliminate completely the permissibility of waiting periods in 2014 for CHIP-eligible children.

## **II. Essential Health Benefits in Alternative Benefit Plans**

### **1. Subpart C- Benchmark Benefit and Benchmark-Equivalent Coverage**

#### **(a) Conforming Changes to Medicaid to Align with Essential Health Benefits**

HHS has clarified coverage requirements under Medicaid and Essential Health Benefits for children under 21, but has not addressed obvious inconsistencies in Medicaid EPSDT coverage for these children depending on how they qualify. We respectfully request that HHS

consider mandating or giving states the option to provide EPSDT coverage to 19 and 20 year olds who qualify under the new low-income adult category or an Alternative Benefit Plan. This would promote consistent coverage for children in this age group, whether they qualify as an optional child group, the mandatory group of former foster care children who are under the age of 21, or as optional low-income adults. Extending EPSDT coverage to all Medicaid child enrollees, including newly enrolled low income 19 and 20 year olds is important for several reasons. Most mental health conditions emerge during mid to late adolescence; substance abuse and other significant behavioral health risks worsen after high school; accidents and injuries from violent acts are at their highest levels; and the prevalence of chronic medical conditions in late adolescence continues to far exceed early childhood rates. Thus, coverage under benchmark or catastrophic plans will likely be insufficient to meet their needs.

We appreciate HHS' clarification of the preventive services benefit under the ACA. However, we urge HHS to retain the current regulatory definition which established that the allowable providers of preventive services are physicians or other licensed practitioners. We disagree that the provider requirement for preventive services under the ACA should be aligned with Medicaid's provider requirement for the optional benefit category "other diagnostic, screening, preventive and rehabilitative services," as established under Section 1905(a)(13). The benefits are distinctly different and have different purposes, particularly for children up to age 21: the services covered under the Medicaid benefit category are expressly intended under the statute to achieve "maximum reductions in physical and mental disabilities and restoration of an individual to the best possible functional level." Moreover, the term "licensed practitioner of the healing arts has been defined by CMS as "any health practitioner who is licensed in the State to diagnose and treat individuals with the physical or mental disability or functional limitations at issue, and operating within the scope of practice defined in State law."

HHS has specifically requested comments on its proposal to add individuals with a substance abuse disorder to the definition of "medically frail" under Section 440.315. We are strongly supportive of this proposal, since 11.9% of adolescents have a diagnosable clinical substance abuse disorder.<sup>vi</sup> Access to more comprehensive benefits under Medicaid will help to ensure that those with substance abuse disorder receive needed treatment.

#### **IV. Medicaid Premiums and Cost Sharing**

##### **2. Update to Maximum Nominal Cost Sharing (Section 447.52)**

As HHS revises its regulations defining nominal cost sharing, we urge the agency not to adopt the proposed nominal cost-sharing option of \$4 for outpatient services and \$50, or \$100 for an inpatient stay for individuals with incomes below 100% of the federal poverty level. Instead, we urge HHS to eliminate cost-sharing for this population. Unfortunately, there are very few current studies that have examined the impact of increased copayments on Medicaid enrollees. Those studies, however, have shown that even nominal copayments of \$2 or \$3 can significantly reduce use of doctor visits and prescription drugs.<sup>vii</sup> Also, from our interviews with adolescent health providers, we know that adolescents, who frequently receive care on their own, are unable to pay co-payments. As a result, they may either forgo needed care or else be treated by provider who are forced to forgo appropriate payment.

With respect to nominal sharing for individuals with incomes above 100% FPL, we urge HHS to not to permit differential cost sharing for preferred and non-preferred drugs when the non-preferred drug is stipulated as medically necessary by the prescribing physician. Financial access to appropriate drug treatment is likely to be particularly important for treating the conditions of medically frail and former foster care children.

We would welcome the opportunity to discuss our comments with you or your staff. If you require any additional information, or have any questions, please contact Harriette Fox at The National Alliance to Advance Adolescent Health ([hfox@thenationalalliance.org](mailto:hfox@thenationalalliance.org)) or Peggy McManus ([mmcmanus@thenationalalliance.org](mailto:mmcmanus@thenationalalliance.org)).

Sincerely,



Harriette B. Fox, CEO



Margaret A. McManus, President

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<sup>i</sup> Dworsky A, Dillman KN, Dion ME, Coffee-Borden B, Rosenau M. *Housing for Youth Aging Out of Foster Care: A Review of the Literature and Program Typology*. Washington, DC: Mathematica Policy Research, April 2012.

<sup>ii</sup> Courtney ME, Dworsky A, Cusick G, Havlicek J, Perez A, Keller T. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21*. Chicago: Chapin Hall Center for Children at the University of Chicago, 2007.

<sup>iii</sup> American Academy of Pediatrics' Council on Foster Care, Adoption, and Kinship Care and Committee on Early Childhood. Health care of youth aging out of foster care. *Pediatrics*. 2012; 130:1170-1173.

<sup>iv</sup> Gold RB, Sonfield A. Reproductive health services for adolescents under the State Children's Health Insurance Program. *Family Planning Perspectives*. 2001; 33: 81-87.

<sup>v</sup> *Policy Brief: The Benefits of Expanding Medicaid Family Planning*. Washington, DC: The National Campaign to Prevent Teen and Unplanned Pregnancies, May 2011.

<sup>vi</sup> *Adolescent Substance Use: America's #1 Public Health Problem*. New York: National Center on Addiction and Substance Abuse at Columbia University, June 2011.

<sup>vii</sup> Ku L, Deschamps E, Hilman J. *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*. Washington, DC: Center on Budget and Policy Priorities, November 2, 2004.