March 17, 2014

By Electronic Submission

Center for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Room C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850

RE: Agency Information Collection Activities: Form CMS-R-5, State Plan Amendment Preprint for Medicaid Cost Sharing

OMB Control Number: 0938-1148

Dear Sir or Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments on CMS' draft preprint for State Plan Amendments (SPAs) concerning Medicaid cost sharing, published in the Federal Register on February 14, 2014.

We generally support CMS' effort to convert SPA preprints into PDF fillable documents to streamline and standardize the administrative process. We also commend CMS for including a clear statement on page 3 of the fillable pdf ("508_Copy of Medicaid Cost Sharing_FINAL_2-3-14_clean2") that requires states to undergo a public comment process for any SPA that establishes or substantially modifies Medicaid cost sharing. Below we offer several suggestions where the draft language appears to deviate slightly from the new Medicaid regulations or would improve transparency in the SPA process by requesting more details from the states.

Comments on draft form CMS-R-5 [OMB Control No. 0938-1148]

<u>Cost-sharing for otherwise exempt individuals</u>

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In the limited cases of copays for nonemergency use of the Emergency Department or for non-preferred medications, the statute permits a state to establish copays for otherwise exempt individuals, so long as the copays do not "exceed nominal limits" as established in §1916. 42 U.S.C. § 1396o-1(c)(2)(B), (e)(2)(B). The nominal limits for cost sharing, as set out in the new regulations, correspond to the maximum allowable cost sharing for individuals with incomes below 100% FPL, as defined in 42 C.F.R. § 447.52(b).

Where the draft preprint describes cost sharing for nonemergency ED use and non-preferred medication (at pages 4,5,6 and 7), it appropriately asks whether the state will charge cost sharing for exempt individuals. If a state answers "yes," the next statement reads "The cost sharing charges …. imposed on otherwise exempt individuals **are the same as the charges imposed on non-exempt individuals."** This statement implies that a state can charge the same cost-sharing for non-exempt individuals and otherwise exempt individuals, though the latter can only be charged based on the nominal cost-sharing limit applicable to individuals below 100% FPL. We recommend that CMS clarify that the statute permits only nominal cost sharing on otherwise exempt individuals.

- **RECOMMENDATION:** Add the bolded qualifying phrase to the relevant sentences discussing cost sharing for otherwise exempt individuals: "The cost sharing charges for [non-preferred drugs or nonemergency ED use] imposed on otherwise exempt individuals are the same as the nominal charges imposed on non-exempt individuals ***with incomes below 100% FPL."***

Beneficiary and Public Notice Requirements

We strongly support the requirement for states to provide a reasonable opportunity for public comment before submitting proposals for substantial cost sharing modifications. We also support the explicit reference to making cost sharing schedule publicly available. However, we recommend that this paragraph require states to post the cost sharing schedule on their Medicaid website. Every state has a Medicaid website and this does not present an undue administrative burden. There is no good reason for a state not to post its cost sharing schedule, but the language in the preprint seems to permit a state to not do so (so long as it used other mechanisms.)

- **RECOMMENDATION:** Add the following phrase to the paragraph on Public Notice Requirements (at page 3): "Consistent with 42 C.F.R. 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. ***This includes posting the schedule to a publicly available website.*** Prior to submitting a SPA which establishes…***"***

Enforceable Cost Sharing

The preprint addresses enforceable cost sharing in two places (at pages 1and 8), but only asks for details about enforceable cost-sharing in the "targeting" follow-up

questions on page 8. A state that does not do any targeting might never see the requirement for additional details on its enforceable cost sharing. A state must provide these details in its SPA proposal so the public will be able to provide meaningful comments on the administration of any enforceable cost sharing measure. We recommend the detailed questions about enforceable cost-sharing be included on page 1.

Aggregate Cost Sharing Limits

We support CMS requirement in the new cost sharing regulations that the 5% aggregate cap apply to *all* Medicaid enrollees on a quarterly or monthly bases. One of the key regulatory requirements for an effective aggregate cap process is that states develop a tracking mechanism that does not rely on beneficiary documentation. The draft preprint correctly acknowledges this requirement. However, we note that in states where a Managed Care Organization tracks each family's incurred cost sharing, there may be additional premiums, copays or other cost sharing incurred by the family for Medicaid services not included in the MCO contract. To account for such cases, the SPA preprint should require states to clearly delineate in its description of the tracking mechanism how the state and the MCO will combine MCO cost sharing with any cost sharing for carved out or additional services to satisfy the regulatory requirement.

- **RECOMMENDATION:** Add the following two additional boxes to the preprint section on aggregate limits, nested under the managed care organization box (at page 15):
    - ***"[y/n] The state, in each contract with a Managed Care entity, clearly delineates the respective responsibilities of MCE and the State with regard to tracking and aggregating all the potential Medicaid premiums and cost sharing in a household, both within and outside of the scope of the MCO's Medicaid services."***
    - ***"The process the state uses to aggregate Medicaid cost sharing identified by the MCO tracking system with any additional Medicaid premiums or cost sharing a family incurs due to Medicaid services accessed outside the scope of the MCO's contract (e.g. carveouts, other individuals not covered by the MCO), is as follows: [ ]"***

Family Income and Medicaid Premiums

While we understand that this collection of information may be strictly limited to Medicaid cost sharing, we note that the general supporting statement for CMS-R-5 also mentions other important provisions of the new Medicaid premium and cost sharing regulations, including Medicaid premiums and the state's process for determining household size and income for cost sharing purposes. The template put up for comment does not mention either of these important issues. Perhaps these other elements are slated for future revisions, but they should undoubtedly be included in whatever final SPA preprint CMS approves for Medicaid Premiums and Cost Sharing.

Thank you again for considering these comments. If you have any questions or need any further information, please contact David Machledt (machledt@healthlaw.org; 202-384-1271), Policy Analyst, at the National Health Law Program.

Sincerely,

Emily Spitzer
Executive Director