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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2334-P
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February 21, 2013

RE: CMS-2334-P: Proposed Rule – Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative benefit plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing

To Whom It May Concern:

The National Association of Community Health Centers, Inc. ("NACHC") is pleased to respond to the above-referenced proposed rule issued by the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("HHS"/ "CMS") on January 22, 2013, published at 78 Fed. Reg. 4594 ("the Proposed Rule"). NACHC is the national membership organization for federally qualified health centers (hereinafter interchangeably referred to as "health centers" or "FQHCs") throughout the country, and is a Section 501(c)(3) tax-exempt organization.

The Proposed Rule is wide-ranging in its scope. NACHC wishes to comment here chiefly on two portions of the Proposed Rule of particular interest and concern to health centers, both relating to the Medicaid program: the proposed revisions to 42 C.F.R. Part 440, Subpart C (Benchmark Benefit and Benchmark-Equivalent Coverage) and the sections of 42 C.F.R. Part 447, Subpart A (Payments: General Provisions) dealing with cost sharing.

The Proposed Rule expands the scope of benchmark and benchmark-equivalent coverage (now referred to as "alternative benefit plans"), a form of medical assistance first authorized in the Deficit Reduction Act of 2005 ("DRA 2005"), to reflect the new mandates in the Affordable Care Act ("ACA"). The ACA requires that newly eligible individuals receive medical assistance through alternative benefit plans, and that the alternative benefit plans include, at a minimum, the "essential health benefits" (or "EHB"). With respect to cost sharing, the Proposed Rule does not implement the ACA, but instead streamlines existing rules promulgated in May 2010, which implemented provisions of DRA 2005 creating new options for states to increase cost sharing obligations for some Medicaid recipients.

In each area, NACHC recommends that CMS re-evaluate some provisions of its Proposed Rule in order to ensure that the amended regulations faithfully implement DRA 2005 and do

not undermine health centers' critical role in supporting the successful expansion of Medicaid in 2014.

With respect to alternative benefit plans, NACHC requests that CMS reaffirm the requirement that coverage under such plans encompass FQHC services, as defined in Section 1905(a)(2)(C) of the Social Security Act ("the Act" or "SSA"), and mandate payment for these services as set forth in SSA § 1902(bb), and that CMS make several minor revisions to the Proposed Rule to reflect these requirements.

With respect to cost sharing, the Proposed Rule both authorizes states to impose higher cost sharing on Medicaid recipients and confers new discretion to condition the provision of services upon a patient's ability to pay the cost sharing. This combination presents difficulties for health centers because of their obligation under Section 330 of the Public Health Service Act ("Section 330") to serve patients regardless of their ability to pay. NACHC therefore recommends below revisions to the Proposed Rule designed to mitigate the potential conflict between the Medicaid cost sharing provisions and health centers' Section 330 obligations.

I. Background on Health Centers

There are, at present, more than 1200 health centers with more than 8000 sites serving more than 20 million patients nationwide. Most of these health centers receive federal grants under Section 330 of the Public Health Service ("PHS") Act, 42 U.S.C. § 254b, from the Bureau of Primary Health Care ("BPHC"), within HRSA. Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be serving a designated medically underserved area or a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent (51%) users of the health center and the health center must offer services to all persons in its area, regardless of one's ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services (such as translation, transportation services, smoking cessation classes, etc.) to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance, whether public or private, are expected to pay for the services rendered. Approximately 35 percent of health center patients are Medicaid recipients, approximately 7.5 percent are Medicare beneficiaries, and approximately 40 percent are uninsured.

II. Comments

The ACA dramatically expands Medicaid eligibility, effective January 1, 2014, by creating a new categorically eligible group comprised of adults under age 65, with incomes under 133% of the federal poverty level ("FPL"), who are not eligible for Medicaid under a pre-existing mandatory eligibility group, and who are citizens or are non-citizens entitled to Medicaid under applicable rules ("the adult group"). This represents the first time that a Medicaid eligibility

category has applied to adults based strictly on income. In states that choose to pursue the expansion, the law makes federally-supported health coverage available for the first time to non-disabled childless adults.

Effective implementation of this unprecedented Medicaid eligibility expansion is important to health centers, just as health center participation is critical to the success of the eligibility expansion. Health centers provide cost-effective and cost-efficient primary and preventive health care and enabling services to a predominantly low-income population, and they embody principles of patient-centered primary care that Congress sought to propagate through various provisions of the ACA. As a result of the coverage expansion under the ACA, health centers' total patient base is projected to rise from 18.8 million in 2008 to 50 million by 2019, and the portion of patients who are Medicaid recipients is expected to rise.[1]

In the main portions of the Proposed Rule that NACHC comments on below (see Parts B and C of our Comments), addressing Medicaid alternative benefit plans and Medicaid cost sharing requirements, CMS revises regulations that it originally promulgated in 2010 to implement DRA 2005, Pub. L. No. 109-171 (2006). DRA 2005 sought to give states more flexibility in their Medicaid programs by allowing them to provide certain groups of Medicaid recipients with a fixed benchmark or benchmark-equivalent coverage, rather than full Medicaid. *See* DRA 2005 § 6044 (enacting new SSA § 1937). DRA 2005 also created a new "alternative" cost sharing authority, SSA § 1916A, which allows states to impose higher cost sharing and premiums, for recipients whose income is greater than 100% FPL and who do not fall within several groups of more vulnerable individuals who are exempted from the alternative cost sharing. *See* DRA § 6041. In each of these provisions, however, Congress carefully balanced the new flexibility given to states with rigorous requirements to ensure that the recipients who are covered under an alternative benefit plan or subject to alternative cost sharing have access to adequate Medicaid services without undue financial burdens.

Both alternative benefit plans and the alternative (Section 1916A) cost sharing authority will play an increasingly prominent role in Medicaid as the program expands to include the adult group. Members of the adult group, unless they fall within certain categories of medically frail individuals statutorily exempted from coverage under alternative benefit plans, *see* SSA § 1937(a)(2)(B), will receive medical assistance consisting of benchmark or benchmark-equivalent coverage. SSA § 1902(k)(1). In addition, states will likely turn increasingly to the alternative cost sharing authority as the Medicaid program expands.

CMS's revisions of the alternative benefit plan and cost sharing provisions in the regulations, 42 C.F.R. Part 440, Subpart C and Part 447, Subpart A, should take into account the critical role that health centers play as primary care homes for the newly eligible adult group. In particular, in the Final Rule, CMS should refine its Proposed Rule as follows: (1) to make clear that coverage under alternative benefit plans must include FQHC services; (2) to ensure that the new cost sharing flexibility afforded to state Medicaid programs through the Proposed Rule conforms to the statutory restrictions in Sections 1916 and 1916A of the Act; and (3) to take

[1] Kaiser Comm'n for Medicaid and the Uninsured, *Community Health Centers: Opportunities and Challenges of Health Reform* (Aug. 2010), Fig. 9.

into account, in finalizing the cost sharing regulations, health centers' role as safety net providers for the uninsured and their obligation to serve patients regardless of ability to pay.

We also request that CMS clarify in the preamble to the Final Rule that nothing in the revised regulations authorizes states to *require* providers to condition the provision of services on a patient's ability to pay the cost sharing, and we urge CMS to make clear that states may not impose on FQHCs, as Medicaid providers, obligations relating to cost sharing that conflict with an FQHC's obligations under Section 330.

Some of the concerns expressed below may be more appropriately addressed through clarifying guidance than through revisions to the Proposed Rule. For example, NACHC urges CMS to provide guidance to states on requirements for the inclusion of FQHC services in alternative benefit plans.

A. Proposed Revisions to 42 C.F.R. § 435.4, 45 C.F.R. § 155.20

NACHC wishes to support the comments of the National Immigration Law Center (NILC) concerning the definition of "lawfully present" in 42 C.F.R. § 435.4 and 45 C.F.R. § 155.20. In particular, we support NILC's proposal that HHS expand the definition of "lawfully present" to include individuals granted deferred action by the U.S. Department of Homeland Security under the Deferred Action for Childhood Arrivals (DACA) policy, effective August 15, 2012.

The definition of the term "lawfully present" can be a life-or-death matter, determining which immigrants will be eligible for coverage through the Exchanges, which children and pregnant women will be eligible for federal Medicaid and CHIP in about half the states, and which immigrants will be left with no option for affordable health coverage. Therefore, we support the most inclusive definition possible, and do not believe that administrative burden alone should be dispositive in deciding whether a given immigration status is included in the definition. The exclusion of individuals who have been granted immigration relief under the DACA process in the Proposed Rule contradicts the purposes and goals of the DACA program, one of which was to integrate young people who meet certain requirements into the fabric of their communities despite their previously undocumented status. In addition, including individuals granted deferred action under the DACA process as "lawfully present" would be a wise policy decision in that it would better fulfill the ACA's goal of expanding access to affordable health insurance by spreading the risk across a population of generally younger, healthier individuals, thereby decreasing the costs of health care for everyone and for the health care system in general. On these points, NACHC commends to HHS the compelling arguments made by NILC on pages 5-7 of its comments.

NACHC also joins with NILC in strongly supporting HHS's decision to include in the definition of "lawfully present" individuals who are lawfully present in American Samoa under the immigration laws of American Samoa.

B. Proposed Revisions to 42 C.F.R. Part 440, Subpart C (Benchmark Benefit and Benchmark-Equivalent Coverage)

NACHC urges CMS, in finalizing the revisions to Part 440, Subpart C, to make clear the statutory requirements (1) that coverage under alternative benefit plans include the full scope of FQHC services referenced in Section 1905(a)(2)(C) of the Act, and (2) that such services must be reimbursed through the prospective payment system (PPS) methodology under SSA §

1902(bb). While these requirements are stated unequivocally in Section 1937(b)(4) of the Act and its implementing regulation, 42 C.F.R. § 440.365, which is unaltered by the Proposed Rule, NACHC is concerned that CMS's proposed revisions to the surrounding sections of Part 440, Subpart C render the FQHC services requirements less explicit.

As states proceed quickly with ACA implementation in 2013, it is critical that CMS make clear to states the full scope of required services for the adult group (as well as other recipients served under alternative benefit plans). NACHC recommends that CMS provide guidance to states on the implementation of the requirement to include FQHC services in alternative benefit plans, with particular emphasis on managed care.

NACHC also recommends that CMS make minor clarifying revisions to the provisions of the Proposed Rule on alternative benefit plans as described below.

1. **FQHC Services and alternative benefit plans**

Under the ACA, the medical assistance provided to the adult group "shall consist of benchmark coverage described in section 1937(b) or benchmark equivalent coverage described in section 1937(b)(2)." SSA § 1902(k)(1). The alternative benefit plans provided to the adult group "shall be provided *subject to the requirements of section 1937*. . . ." *Id.* (emphasis added). Section 1937, in turn, requires that the package of benefits provided under an alternative benefit plan include coverage of rural health clinic and FQHC services. Specifically:

> Notwithstanding the previous provisions of [Section 1937], a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark equivalent coverage under this section unless –
>
> (A) the individual has access, through such coverage or otherwise, to services described in subparagraphs (B) and (C) of section 1905(a)(2); and
> (B) payment for such services is made in accordance with the requirements of section 1902(bb).

SSA § 1937(b)(4); *see also* 42 C.F.R. § 440.365.

Nothing in the ACA altered this core requirement. The ACA imposed, in addition to preexisting requirements in SSA § 1937, the requirement that the alternative benefit plans offered to the adult group "provide *at least* essential health benefits as described in [PPACA § 1302(b)]." SSA § 1937(b)(5) (emphasis added). (The ACA also imposed new requirements that alternative benefit plans include coverage for mental health services and prescription drugs.) As CMS reiterated in the preamble to the Proposed Rule, "[t]he Affordable Care Act modified section 1937 of the Act to implement two standards for minimum coverage provision; not only must EHBs as defined by the Secretary be provided, *but all requirements of section 1937 of the Act continue to apply*." 78 Fed. Reg. at 4630 (emphasis added).

The EHBs are thus a *floor* for alternative benefit plan coverage. The requirement to provide the EHBs within alternative benefit plans does not reduce any preexisting requirements in Section 1937. Whether or not an EHB package encompasses FQHC services, as those services are defined in Social Security Act § 1905(a)(2)(C), states are obligated to provide FQHC services as part of an alternative benefit plan.

Congress was particularly careful in enacting Section 1937(b)(4) to ensure that states complied with the requirement to provide FQHC services whether or not those services are included in a managed care plan through which benchmark or benchmark-equivalent coverage is provided. This explains the use of the phrase "*through such coverage or otherwise"* in Section 1937(b)(4), quoted above. CMS emphasized this point in the preamble to the April 30, 2010 final rule implementing the DRA 2005 benchmark provisions. *See* CMS, Final Rule, Medicaid Program; State Flexibility for Medicaid Benefit Packages, 75 Fed. Reg. 23,068, 23,090 (Apr. 30, 2010) ("We also agree that individuals always have access to FQHC services, even if the state does not contract with an FQHC to provide such services, and we encourage states to contract with FQHCs as providers.").

In light of this background, NACHC requests that CMS reiterate or clarify its revisions to the following regulations.

2. **Proposed 42 C.F.R. § 440.330 (Benchmark health benefits coverage)**

CMS proposes to revise its present regulation on benchmark coverage to make clear that states may include within a "Secretary-approved coverage" package not only the types of Medicaid benefits covered under Section 1905(a) of the plan, but also state plan home- and community-based services, self-directed personal assistance services, and health home services.

NACHC supports this decision. This broad description of the services that may be included in "Secretary-approved coverage" is the only reasonable interpretation of Section 1937, which permits the coverage to include "[*a]ny health benefits coverage* that the Secretary determines . . . provides appropriate coverage for the population proposed to be provided such coverage." SSA § 1937(b)(1)(D) (emphasis added). As CMS made clear in State Medicaid Director Letter 12-003 (Nov. 20, 2012), states are welcome to select, as their alternative benefit plan, a coverage corresponding to their full traditional Medicaid benefit, which they would present to the Secretary as their proposal for the "Secretary-approved coverage" benchmark. This distinguishes the Section 1937 benchmark options from the essential health benefits benchmark options for set forth in HHS's proposed rule issued on November 26, 2012 (77 Fed. Reg. at 70,644), which are based solely on commercial insurance.

Moreover, as the National Health Law Program noted in its comments on the Proposed Rule, states may include in their proposed Secretary-approved coverage package benefits described in the listed statutory sections, *even if those benefits are not otherwise provided under the State plan.* (*See* Comments of National Health Law Program, page 38.)

3. **Proposed 42 C.F.R. § 440.335 (Benchmark-equivalent health benefits coverage)**

There appears to be a typographical error in the proposed revisions to subsection (c)(1), which provides that "benchmark-equivalent coverage may include coverage for any additional benefits of the type which are covered in 2 or more of the standard benchmark coverage packages described in § 440.330(a through c). . . ." 78 Fed. Reg. at 4700. The preamble indicates CMS' intent to "clarify [in proposed 42 C.F.R. § 440.330(d)] that Secretary-approved coverage may include benefits of the type which are covered in *1 or more* of the section 1937 of the Act commercial coverage packages. We are also clarifying § 440.335(c) and § 440.360 in the same way." 78 Fed. Reg. at 4631 (emphasis added).

Recommendation: Since proposed §§ 440.330(d) and 440.360 both refer to *one* or more of the commercial coverage packages, we assume that the reference in § 440.335(c) should be the same.

4. **Proposed 42 C.F.R. § 440.345 (EPSDT and other required benefits)**

In its present form, 42 C.F.R. § 440.345 requires the state to "assure access to early and periodic screening, diagnostic and treatment (EPSDT) services through benchmark or benchmark-equivalent plan benefits or as additional benefits provided by the state" for children entitled to EPSDT. CMS proposes to append to the regulation three additional requirements for alternative benefit plans emanating from the ACA: compliance with the Mental Health Parity and Addiction Equity Act, inclusion of at least the EHB in an alternative benefit plan, and coverage of family planning services and supplies. CMS also proposes to specify in the revised regulation that states are not required to update alternative benefit plans that have been determined to include essential health benefits as of January 1, 2014, until December 31, 2015.

As amended by the Proposed Rule, the regulation includes -- with the notable exception of RHC/FQHC services -- all of the additional statutory requirements concerning alternative benefit plan coverage that fall outside the scope of §§ 440.330 and 440.335, the sections listing the minimum contents of each benchmark or benchmark-equivalent coverage plan. CMS also omitted mention of FQHC services in the portions of the preamble discussing these additional statutory requirements. *See* 78 Fed. Reg. at 4631.

NACHC is concerned that the omission of FQHC services from the list in § 440.345 creates the impression that these services are not a required benefit within Section 1937 coverage, since the revised § 440.345 contains an otherwise-exhaustive list of requirements.

Recommendation: NACHC recommends that, in light of CMS's revisions to 42 C.F.R. § 440.345, CMS either consolidate § 440.345 with 42 C.F.R. § 440.365 (Coverage of rural health clinic and FQHC services) or incorporate § 440.365 by reference into § 440.345.

5. **Proposed 42 C.F.R. § 440.347 (Essential health benefits)**

This proposed new regulation defines the "essential health benefits" that alternative benefit plans are required to include, per proposed 42 C.F.R. § 440.345(d).

This provision duplicates the content of proposed § 440.345(d) in a potentially confusing manner. Proposed § 440.345(d) provides that any alternative benefit plan must include "*at least* the essential health benefits described in § 440.347." Proposed § 440.347, which, per § 440.345(d), is a regulation whose purpose is to define "essential health benefits," restates that mandate.

Recommendation: NACHC recommends that CMS clarify in the regulation that essential health benefits form a *floor* for the alternative benefit plans and do not supplant any preexisting requirements under Section 1937 and 42 C.F.R. Part 440, Subpart C. In particular, the regulation as drafted is confusing because the mandate to provide essential health benefits is phrased differently in subsections (a) (describing the requirement to include at least the ten categories of essential health benefits) and (b) (describing the requirement to include the benefits covered in one of the state-selected benchmark plans), with subsection (a) failing to

specify that the Section 1937 benchmark package must include *"at least"* the essential health benefits. In addition, it is confusing that the mandate is stated separately in subsections (a) and (b) of proposed § 440.347, because in fact, those two subsections collectively define the single concept of "essential health benefits," as that concept is defined in 45 C.F.R. Part 156.

In NACHC's view, the regulations would be clearer if § 440.347 were worded exclusively as a definition of EHB, rather than a restatement of the mandate to include EHB in alternative benefit plans. Also, clarity may be better served if the regulation simply defines EHB by reference to the relevant provisions in 45 C.F.R. Part 156.

6. **Proposed 42 C.F.R. § 440.360 (State plan requirements for providing additional services)**

In its present form, 42 C.F.R. § 440.360 provides, "In addition to the requirements of § 440.345 the state may elect to provide additional coverage to individuals enrolled in benchmark or benchmark-equivalent plans," and sets forth related requirements.

CMS proposes to revise the regulation to provide, as an exception, "that the coverage for [members of the adult group] who are not exempt is limited to benchmark or benchmark equivalent coverage."

NACHC is concerned that the proposed regulation fails to distinguish clearly between required and "additional" benefits for the Section 1937 package. 42 C.F.R. § 440.360, concerning "additional coverage," takes on new significance in the post-ACA context, because for the adult group, medical assistance must consist of benchmark or benchmark-equivalent coverage. *See* SSA § 1902(k)(1). In the Proposed Rule, CMS has construed this statutory provision to mean that members of the adult group *may not receive* as "medical assistance" any Medicaid services described in Section 1905 outside the benchmark or benchmark-equivalent package.

The final regulation should distinguish between, on the one hand, the cumulative group of benefits and services that states are required to provide as part of the coverage under alternative benefit plans (FQHC services and, where applicable, EPSDT and family planning services and supplies); and on the other hand, the benefits and services considered "additional" per § 440.360 (*i.e.,* any other service or benefit included in a Medicaid benchmark plan or in the state plan pursuant to the statutory provisions listed in the regulation).

Through the opening phrase of proposed § 440.360, "In addition to the requirements of § 440.345," the Proposed Rule acknowledges the mandate to provide family planning services and EPSDT services, and to ensure that mental health parity requirements are met, under alternative benefit plans. This provision is silent, however, on states' obligation to provide FQHC services as part of Section 1937 coverage.

NACHC wishes to emphasize that Section 1937 requires states (1) to provide FQHC services to recipients who receive coverage under alternative benefit plans to the full extent those services are covered under Social Security Act § 1905(a)(2)(C), and (2) to pay for such services as provided in Social Security Act § 1902(bb). *See* Social Security Act § 1937(b)(4). Thus, the FQHC services available to a Medicaid recipient enrolled in an alternative benefit plan must include both federally-qualified health center services, as defined in Section 1905(*l*)(2)(A) of the Act, and "any other ambulatory services offered by a Federally-qualified health center

and which are otherwise included in the [state] plan." SSA § 1905(a)(2)(C). Payment for such services must be made according to the cost-related prospective payment system (PPS), as specified in Section 1902(bb) and in the state plan, with state supplemental payments provided where the PPS payment would exceed the amount provided for under the managed care contract. SSA § 1902(bb)(5).

If a state provides alternative benefit plans solely through managed care, and for any reason, FQHC services are unavailable to enrollees under their managed care plan (for example, where a state is permitted through a waiver to restrict the availability of FQHC services under managed care, or where no FQHCs are included in a particular managed care organization's network), then the state must otherwise provide the recipient enrolled in alternative benefit plan coverage with FQHC services on a per-visit basis as required by Section 1902(bb). CMS conveyed its conclusion to this effect in the preamble to its April 2010 final rule implementing the benchmark provisions in DRA 2005. *See* CMS, Final Rule, Medicaid Program; State Flexibility for Medicaid Benefit Packages, 75 Fed. Reg. 23,068, 23,090 (Apr. 30, 2010). NACHC notes that CMS's present (pre-ACA) State Plan preprint for benchmark and benchmark-equivalent coverage accurately states these requirements.

These requirements apply identically to the adult group and to other Medicaid recipients enrolled in an alternative benefit plan.

Recommendation: NACHC recommends that CMS clarify the FQHC services requirement by consolidating § 440.365 into § 440.345, or by independently referencing 42 C.F.R. § 440.365 in 42 C.F.R. § 440.360. If CMS chooses to add a reference to the FQHC services requirement, the first sentence of 42 C.F.R. § 440.360 would begin, "In addition to the requirements of § 440.345 *and § 440.365*. . . ."

7. **Proposed 42 C.F.R. § 440.385 (Delivery of benchmark and benchmark-equivalent coverage through managed care entities)**

This regulation, which is not affected by the Proposed Rule, requires that if benchmark or benchmark-equivalent coverage is provided through a managed care entity, states must comply with the managed care requirements at Section 1932 of the Act and 42 C.F.R. Part 438.

Recommendation: Consistent with the comments above, NACHC recommends that CMS add a sentence to this regulation clarifying the requirement to provide outside of managed care any required component of an alternative benefit plan that is not offered through a managed care entity. The sentence could read as follows:

> If a managed care entity does not cover any benefit required to be included in an alternative benefit plan or otherwise required to be provided under this Subpart, either because the benefit is not included in the managed care entity's contract with the State or because the managed care entity's provider network does not include providers of such benefit, the State must nonetheless make the benefit available to beneficiaries served under an alternative benefit plan.

C. Proposed Revisions to 42 C.F.R. Part 447, Subpart A (Payments: General Provisions)

As states pursue the Medicaid expansion, the prevalence of cost sharing in the program is likely to increase. Medicaid cost sharing regulations that are clear and that observe the limits set forth in Sections 1916 and 1916A of the Act will be critical in ensuring that recipients do not experience unnecessary barriers to care.

In this Proposed Rule, CMS proposes to delete the cost sharing regulations in their entirety, and replace them with the proposed regulations set forth at 78 Fed. Reg. 4701 through 4705. These changes do not implement ACA requirements. Instead, as the preamble explains, they are intended to streamline and simplify currently applicable rules and to reduce the redundancies between the rules implementing Section 1916 of the Act (Use of enrollment fees, premiums, deductions, cost sharing, and similar charges) and those implementing Section 1916A (state option for alternative premiums and cost sharing). *See* 78 Fed. Reg. at 4658.

NACHC has concerns about the impact of the Proposed Rule on health center payment and on recipients' access to care. CMS has deleted or dramatically altered several major components of the cost sharing rules without explaining the rationale for these changes in the Proposed Rule. The Proposed Rule changes the Medicaid reimbursement ground rules for FQHCs and other safety net providers by allowing the provision of medically necessary services to be conditioned on the collection of cost sharing.

Further, the Proposed Rule departs from the statute by rejecting the distinction between the generally-applicable cost sharing rules in Social Security Act 1916 and the "alternative" rules in Section 1916A – an authority that states must specifically invoke through a state plan amendment, per the statute, in order to impose increased cost sharing responsibilities on recipients. The result will be less clarity for providers and recipients as to which rules apply.

Equally concerning is the fact that the Proposed Rule deletes the provisions in the regulations concerning limitations on CMS waiver authority in matters concerning Medicaid premiums and cost sharing. To promote transparency, CMS should restore 42 C.F.R. § 447.62(b), which provides that waivers relating to "deductions, cost sharing, and similar charges may be granted only in accordance with the provisions of section 1916(f) of this Act" – *not* under other waiver authorities, such as Section 1115 of the Act.

Finally, some of the specific proposals for increased state flexibility to impose cost sharing – for example, the proposal to define "nominal" as $8, for the purposes of establishing co-payments for non-preferred drugs for recipients within income below 150% FPL, but to define "nominal" as $4 for all other purposes (including for preferred drugs) – appear to us to be in tension with the terms of Section 1916A of the Act.

NACHC recommends that CMS clarify or revise the provisions in the Proposed Rule as described below in order to address these concerns.

1. Proposed 42 C.F.R. § 447.52 (Cost sharing)

In this provision, CMS proposes (1) to update the "nominal" amounts of cost sharing applicable to recipients with income at or below 100% FPL; (2) to consolidate the generally-

applicable cost sharing limits set forth in Section 1916 of the Act with the "alternative" limits set forth in Section 1916A of the Act for recipients whose income exceeds 100% FPL; (3) to permit "targeted cost sharing"; (4) to modify the provisions concerning "denial of service for nonpayment," located in the present 42 C.F.R. § 447.53(e) in order to give states greater discretion to allow providers to condition service on payment of cost sharing; and (5) to modify the provisions concerning "state plan specifications" regarding cost sharing, which are located in the present 42 C.F.R. § 447.53(d).

a. Updating nominal cost sharing amounts; consolidating Section 1916 and Section 1916A authorities

Concerning 42 C.F.R. § 447.52(b), NACHC does not disagree with CMS's proposal to streamline the rules by updating the amount considered "nominal" for outpatient services to $4, postponing the next adjustment of the amount to the year beginning October 1, 2015, and removing the "nominal" amounts in the present regulations that are associated with outpatient services for which the state payment is less than $50. We note, however, that CMS has omitted the term "nominal" in the regulations, instead referring only to the "maximum allowable cost sharing." Section 1916 of the Act specifically limits cost sharing to "nominal" amounts, and commands the Secretary to determine the "nominal" amounts in each year. "Nominal" is the substantive standard in Section 1916 for cost sharing responsibilities for individuals with household income at or below 100% FPL who are not exempt from cost sharing, and where the alternative authority of Section 1916A is not invoked in the state plan, it forms the standard for all recipients. *See* SSA § 1916(a)(3). This term conveys the statutory requirement that cost sharing burdens on Medicaid recipients not be onerous. We recommend that CMS restore the use of the term "nominal," as that term is used in the existing regulations. *See* 42 C.F.R. § 447.53(a).

More generally, CMS explains in the preamble that it has restructured the regulations to remove the distinction between the generally-applicable (Section 1916) and "alternative" (Section 1916A) cost sharing requirements, and that the revisions are intended to reduce complexity and give states greater flexibility. In NACHC's view, the new structure is in tension with statutory requirements and will result in reduced transparency. The Act characterizes the alternative premium and cost sharing provisions in Section 1916A as measures that a state may elect "at its option and through a State plan amendment." SSA § 1916A(a)(1). Accordingly, the regulations as presently in force (promulgated at 75 Fed. Reg. 30,244 (May 28, 2010)) treat Section 1916A as a separate, alternative statutory authority for cost sharing and require states to provide specific public notice when they intend to invoke the alternative authority through a plan amendment.

CMS has departed from the statutory structure by rejecting the distinction between the two authorities, subjecting "all cost sharing . . . to a single set of parameters." 78 Fed. Reg. at 4568. This distinction is not without consequence, because under the statute, unless a state invokes the alternative authority, its cost sharing policies are evaluated under Section 1916(a) and (b) of the Act. Moreover, Section 1916A includes additional types of flexibility not directly related to the amount of cost sharing; for example, it is only with respect to the alternative cost sharing under Section 1916A that states may permit providers to condition the provision of services on payment of cost sharing. SSA § 1916A(d)(2). Clear, understandable regulations on

cost sharing are critical, because the cost sharing rules impact recipients' access to services, and their implementation is a significant undertaking for providers.

Recommendation: To promote clarity and carry out the statutory provisions, NACHC recommends that CMS restore the distinction between the 1916 and 1916A cost sharing authorities in the regulations.

With respect to the maximum cost sharing for recipients with income over 100% FPL, NACHC requests that CMS clarify how the applicable limits would apply to FQHC services reimbursed under the prospective payment system (PPS) rate. Those limits are "10% of the cost the agency pays," for individuals with family income 101-150% FPL; "20% of the cost the agency pays," for individuals with family income equal to or greater than 150% FPL. 78 Fed. Reg. at 4702. If services reimbursed under the PPS rate were reimbursed as a percentage of "the cost the agency pays," this would mean that the maximum allowable cost sharing obligation for a visit would differ from health center to health center (since each health center has a different PPS rate). This would be administratively burdensome for the state, for managed care plans, and for providers.

Moreover, a co-payment of 10% of the PPS rate for individuals with family income 101-150% FPL, and 20% of the PPS rate for individuals with family income above 150% FPL, would impede access to care for these low-income health center patients. NACHC agrees with the comment of the National Health Law Program that in general, in determining cost sharing responsibilities for low-income individuals, "the cost of the service to the agency is not the relevant factor." *See* Comments of National Health Law Program, p. 48. The amount of cost sharing should take into account the burden of the co-payment on the low-income patient and should be developed with the goal of ensuring that cost sharing is not a barrier to care.

NACHC recommends that, in order to simplify the application of the maximum allowable cost sharing to PPS payment and to restore a more reasonable co-payment amount, CMS revise the Proposed Rule to provide that the maximum cost sharing for FQHC services reimbursed under the PPS, for all Medicaid recipients, is the same as the maximum rate for individuals with income at or below 100% FPL (*i.e.,* the "nominal" rate, or $4). We believe that establishing this maximum cost sharing for FQHC services is within CMS's discretion, as CMS has chosen to establish the maximum co-payments in this manner in states that do not have fee-for-service payment rates. *See* proposed 42 C.F.R. § 447.52(b)(2), 78 Fed. Reg. at 4702.

Moreover, we note that the Medicare FQHC cost sharing rules support the use of an approach under which the co-payment is not based on the payment rate an FQHC receives from the payor. Under Medicare, for any one item or service furnished by an FQHC, the coinsurance liability "may not exceed 20 percent of a reasonable amount customarily charged by the center for that particular item or service" -- *not* 20% of the FQHC's cost-based rate. 42 C.F.R. § 405.2410(b)(2)(ii).

b. Targeted cost sharing

With respect to proposed 42 C.F.R. § 447.52(c), NACHC has concerns regarding the provision for "targeted cost sharing." Specifically, since cost sharing impacts the scope of services, it is not clear to us how states could apply cost sharing charges only to specific groups (for example, to the adult group, or to low-income families eligible under Section 1931 of the

Act) within the categorically needy population without violating the comparability requirements at 42 C.F.R. § 440.240.

The existing Medicaid regulations implicitly acknowledge that disparate cost sharing requirements for different categorically needy groups would violate comparability. The regulations provide, at § 440.250(*l*), that a state does not violate comparability merely by adhering to specific statutorily mandated cost sharing exemptions. By implication, this suggests that CMS considers that states *would* violate comparability if they exempted categorically eligible groups *other than* those exempted by statute. An informal CMS guidance on cost sharing released in 2012 confirms this interpretation, stating that under Section 1916, "due to comparability requirements states cannot elect to exempt other groups of individuals [other than those specifically exempted by statute]."

Moreover, NACHC does not interpret Section 1916A as conferring this type of authority with respect to alternative cost sharing. The statute provides: "Nothing in this paragraph [listing certain services and eligibility groups exempted from alternative cost sharing under Section 1916A] shall be construed as preventing a state from . . . exempting additional *individuals or services from cost sharing under subsection (a)."* SSA § 1916A(b)(3)(C) (emphasis added). This provision recognizes the discretion of states or providers to exempt recipients from cost sharing on a case-by-case basis (a principle also reflected in SSA § 1916A(d)(2)), and to apply cost sharing only to certain services. It does not recognize or confer an authority to exempt entire groups of categorically needy recipients (other than those statutorily exempted) from the cost sharing requirements.

Recommendation: NACHC recommends that CMS delete proposed 42 C.F.R. § 447.52(c), relating to "targeted cost sharing."

c. Denial of service for nonpayment

Proposed 42 C.F.R. § 447.52(d) raises an issue of particular concern for health centers: the balance between a provider's duty to collect cost sharing and its duty to ensure that patients receive medically necessary care. The Proposed Rule both authorizes states to increase recipients' cost sharing responsibility and authorizes provider discretion to condition services on the ability to pay the cost sharing. It may result in tension between health centers' responsibilities with respect to Medicaid cost sharing and their obligations under the Section 330 grant to serve patients regardless of ability to pay.

The regulations as currently in effect prohibit providers from denying services based on ability to pay. *See* 42 C.F.R. §§ 447.53(e), 447.15.[2] Proposed 42 C.F.R. § 447.52(b), on the other hand, states: "The agency may permit a provider, including a pharmacy or hospital, to require an individual to pay cost sharing as a condition for receiving the item or service" if the individual has family income above 100% FPL, does not fall within a group exempt from cost sharing, and with respect to non-emergency services furnished in an emergency department,

[2] CMS's Proposed Rule deletes 42 C.F.R. § 447.53 and replaces it in full, but the Proposed Rule does not include a revision of 42 C.F.R. § 447.15 to delete the sentence, "However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost sharing amount imposed by the plan in accordance with § 441.53(g) or § 447.53." If CMS intends to finalize proposed 42 C.F.R. § 447.52(b), we recommend that CMS amend § 447.15 accordingly.

certain other conditions are satisfied. 78 Fed. Reg. at 4702. Only with respect to other categories of recipients – *i.e.,* those with income under 100% FPL or who fall within an exempt group – does the general rule apply that "the state plan must specify that no provider may deny services to an eligible individual on account of the individual's inability to pay the cost sharing." *Id.*

The revised regulation limits the prohibition quoted above to the types of cost sharing described in Section 1916 of the Act, leaving states discretion to impose a different rule with respect to Section 1916A (alternative) cost sharing. NACHC recognizes that this new provision in the Proposed Rule essentially paraphrases Section 1916A(d)(2) of the Act. Moreover, we recognize that Proposed Rule merely gives states authority to *permit,* not to require, providers to condition services upon cost sharing payments. Nonetheless, we wish to point out two respects in which the provisions of the Proposed Rule on cost sharing make it more difficult for health centers to carry out their responsibilities under their Section 330 grants and to receive adequate Medicaid reimbursement. We set forth below several revisions CMS could make to the regulation, or clarifications it could provide, to minimize the potential conflict between the Medicaid cost sharing rules and Section 330.

First, the Proposed Rule is in tension with health centers' mission under their Section 330 grants. Health centers are required to "assure that no patient will be denied health care services due to an individual's inability to pay for such services," and to "assure that any fees or payments required by the center for such services will be reduced or waived to enable the center to fulfill" the prior assurance. 42 U.S.C. § 254b(k)(3)(G)(iii). Up to the present, the Medicaid regulations have echoed this requirement, providing: "No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing." 42 C.F.R. § 447.53(e); *see also id.* § 447.15.

Recommendation: NACHC requests that CMS clarify in the preamble to its Final Rule that the provision concerning denial of service for nonpayment (proposed 42 C.F.R. § 447.52(d)) is permissive only – *i.e.,* it gives states leeway to *allow* providers to proceed in that manner. It does not confer authority on states to *require* that providers deny services if a recipient is unable to pay the cost sharing.

NACHC also recommends that CMS specifically acknowledge in the preamble to the Final Rule health centers' statutory responsibility to provide services regardless of ability to pay. The Proposed Rule at 42 C.F.R. § 447.52(d)(3) provides: "Nothing in this section shall be construed as prohibiting a provider from choosing to reduce or waive such cost sharing on a case-by-case basis." We request that CMS include a statement in the preamble recognizing that health centers are obligated under their Section 330 grants to reduce or waive cost sharing that is a barrier to care, and that in some instances, this may result in a health center's waiving or reducing cost sharing on an *aggregate basis, rather than a case-by-case basis*.[3] We further

[3] Say, for example, that according to the sliding fee scale of a health center in State A, a patient with income of 151-200% FPL would be charged $25 per physician visit. State A has amended its State plan to impose the maximum allowable co-payment (20% of the agency's payment for the service), for Medicaid outpatient services for patients in this income range, and for this health center, that would equal a $32 co-payment for PPS encounters. The health center would routinely (rather than on a case-by-case basis) grant a reduction of $7 per visit for patients in the 151-200% FPL range. Such an across-the-board reduction would be consistent with the safe

recommend that CMS make clear in the preamble that states may not impose on health centers any requirement to collect cost sharing that would directly conflict with health centers' Section 330 obligations.

Second, the Proposed Rule – by both authorizing increased cost sharing and providing that a state's payment to the provider is automatically reduced by the cost sharing obligation – makes it more likely that health centers will receive inadequate payment under Medicaid. Specifically, the health center will receive an insufficient Medicaid payment whenever the Medicaid cost sharing associated with a service is higher than the amount of patient responsibility authorized under the health center's Section 330-compliant schedule of discounts for low-income patients. As noted above, health centers are required under Section 330 to serve patients regardless of ability to pay, and to reduce or waive charges in order to fulfill that requirement. At the same time, pursuant to the existing Medicaid regulations and Proposed Rule, the state Medicaid agency's payment to providers is reduced by the amount of the recipient's cost sharing obligation, regardless of whether the provider has reduced or waived any portion of that obligation. *See* 42 C.F.R. § 447.57(a); proposed 42 C.F.R. § 447.56(c), 78 Fed. Reg. at 4704.

Where Medicaid cost sharing exceeds amounts that the health center can collect in keeping with its Section 330 obligations, the health center will therefore be forced (1) to collect less-than-full reimbursement under Medicaid (by absorbing the cost of any reduction in cost sharing that the health center offers to a Medicaid recipient), or (2) to treat Medicaid recipients who are unable to fulfill their cost sharing requirements as uninsured.

There is a significant risk of this occurring, given the new flexibility conferred on states in the Proposed Rule to impose higher cost sharing for outpatient services and prescription drugs for recipients with family income above 100% FPL. For patients with family income greater than 100% but equal to or less than 200% FPL, health centers are required under Section 330 to establish a "schedule of discounts adjusted on the basis of the patient's ability to pay," 42 C.F.R. § 51c.303(f) – *i.e.,* a sliding fee scale. As HRSA indicated in draft guidance issued in July 2012, individuals who are "underinsured" (including those who have Medicaid coverage but bear cost sharing responsibilities) "may not pay more than uninsured patients in the same income category." *See* HRSA, Clarification of Sliding Fee Discount Program Requirements – Draft for Comment (July 9, 2012), p. p. 12. Thus, for example, if the cost sharing for a service for a patient at 150% FPL (for example, $8 for a prescription, per the Proposed Rule) exceeded the patient's liability under the health center's schedule of discounts for its pharmacy (for example, $5), then the health center would be required to absorb the difference (here, $3) between the two amounts.

By accepting insufficient payment, the health center would violate its obligations under Section 330, which provides that the Secretary may not approve a Section 330 grant application unless the Secretary determines that a health center "has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing

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harbor under the Anti-Kickback statute, *see* 42 C.F.R. § 1001.952(k)(2) and with HRSA guidance, and would not violate the Medicaid regulations.

health services to persons who are entitled . . . . to medical assistance under a State plan approved under title XIX. . . ." 42 U.S.C. § 254b(k)(3)(F).

Cost sharing rules that lead to inadequate FQHC reimbursement under Medicaid payment also undermine Congress' intent in enacting a cost-related payment methodology. The clarity of Congress' intent on this point is conveyed in a House Report associated with the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, which set forth the original cost-related payment methodology for health centers -- a methodology subsequently refined, through PPS, in the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554. The Report indicated that Congress' core purpose in implementing a cost-related reimbursement system was to ensure that Medicaid payments to health centers at least met the health center's allowable service costs. The Report noted that in the past, because Medicaid payments to health centers were inadequate in many states, Section 330 funds ostensibly dedicated to covering the costs of serving the uninsured had been used to subsidize the costs of serving Medicaid patients. H.R. Rep. No. 101-247, at 393 (1989).

Recommendations: NACHC recommends that in order to resolve this predicament, CMS include in 42 C.F.R. § 447.56(c) an exception from the general rule that the state Medicaid agency's payment to providers is reduced by the amount of the recipient's cost sharing obligation. The exception would allow the health center to claim, for any service for which it is entitled to PPS, the full PPS rate, less any cost sharing that the health center actually collected pursuant to its fee policies. (Please see our comment below at page 20 for a more detailed explanation of the proposal.)

Alternatively, we recommend that CMS establish $4 as the across-the-board maximum allowable cost sharing for FQHC services reimbursed at the PPS rate, as suggested above in our Comments at page 12. This would have the dual advantages of (1) ensuring that the cost sharing maximum for FQHC services is one fixed rate (rather than a different maximum, based on percentage of PPS, for each health center); and (2) making it less likely that the Medicaid cost sharing for beneficiaries with family income above 100% FPL exceeds the amounts established as consistent with the patient's ability to pay under its Section 330-compliant sliding fee scale policies.

At a minimum, NACHC recommends that CMS and HRSA confer in producing guidance to states and health centers to minimize the tension between the Medicaid and Section 330 regulations concerning patient payment obligations.

d. State plan specifications

Proposed 42 C.F.R. § 447.52(f) lists the information that must be included in the state plan with respect to each cost sharing charge imposed. This represents a revised version of current 42 C.F.R. § 447.53(d). CMS provided no discussion in the preamble of its rationale for the revisions.

Recommendations: NACHC recommends that CMS add the following items. First, for the reasons described above, the state plan should identify whether a cost sharing charge is being imposed under the authority of Section 1916 or Section 1916A. Second, we recommend that the state plan section listing cost sharing charges be required to include a provision stating

that providers are not prevented from reducing or waiving the application of a cost sharing requirement on a case-by-case basis.

2. **Proposed 42 C.F.R. § 447.53 (Cost sharing for drugs)**

CMS proposes here new provisions concerning cost sharing for drugs, which reflect a revision of the provisions currently codified at 42 C.F.R. §§ 447.70(c)-(d), 447.71(b)(2), and 447.72(b)(1).

In NACHC's view, CMS's proposal to increase the cost sharing on non-preferred drugs for individuals with household income at or below 150% FPL from its present rate ("nominal," with a maximum of $3.90) to $8 per prescription is unauthorized in Section 1916A. Section 1916A provides that for individuals in this income range, cost sharing for non-preferred drugs cannot exceed "the amount of nominal cost sharing (as otherwise determined under section 1916). . . ." SSA § 1916A(c)(2)(A)(i). CMS proposes here, solely for the purpose of non-preferred drugs, to define the applicable amount of "nominal" cost sharing as $8. *See* 78 Fed. Reg. at 4659 ("we are proposing to define nominal for this purpose so as to allow cost sharing of up to $8 for non-preferred drugs for individuals with income equal to or less than 150 percent FPL or who are otherwise exempt from cost sharing"). CMS does not use the term "nominal" in the proposed regulation itself, instead providing only that the "maximum allowable cost sharing" for this category is $8. "Nominal" would have its otherwise-applicable meaning ($4) for preferred drugs. 78 Fed. Reg. at 4702.

It would be understandable if CMS defined the term "nominal" differently for different categories of services – for example, differently for drugs than for outpatient services; however, defining the standard differently for two categories of drugs appears to be an attempt to circumvent the statutory requirements.

This is particularly true given that Section 1916A contains detailed restrictions on cost sharing for specific categories of services. For example, exclusively for non-emergency care furnished in a hospital emergency department (ED), Section 1916A confers on states the authority to impose cost sharing that "may not exceed twice the amount determined to be nominal under section 1916" for individuals with income between 100% and 150% FPL. SSA § 1916A(e)(2)(A). Had Congress intended to authorize states to impose twice the nominal cost sharing for non-preferred drugs for recipients in this income category – effectively, the $8 rate that CMS has proposed here – then it would have used the same language that it used for non-emergency use of the ED.

Legal concerns aside, NACHC is also of the opinion that $8.00 is too high to be a "nominal" co-payment for low-income individuals, and this co-payment could impose a significant barrier to Medicaid recipients in obtaining needed prescriptions.

Recommendations: NACHC recommends that CMS use the same definition of "nominal" for preferred and for non-preferred drugs. In addition, NACHC supports the comments of the National Health Law Program, which noted that the co-payments that CMS proposes for drugs are significantly higher than those used in the Part D low-income subsidy program, and recommended that CMS determine nominality by reference to the LIS co-payments. *See* Comments of National Health Law Program, p. 50.

3. **Proposed 42 C.F.R. § 447.54 (Cost sharing for services furnished in a hospital emergency department)**

CMS proposes here to increase states' flexibility to impose cost sharing for non-emergency services furnished in a hospital emergency department (ED).

In general, NACHC supports the provisions of DRA 2005 enabling states to impose higher cost sharing in the circumstance of non-emergency use of the ED than in the case of other outpatient services. The statute provides that in order for the heightened cost sharing to be imposed, the ED must inform the recipient that it has made a determination that he or she does not have an emergency medical condition and that, before providing treatment, the ED must provide the recipient with a referral to an alternate provider in the community (such as a community health center) that can provide the services without the imposition of Section 1916A cost sharing. SSA § 1916A(e)(1)(B). Health centers around the country have established emergency room care coordination arrangements with hospitals in order to facilitate such referrals. Health centers are a critical resource in ensuring that effective primary care is made available to Medicaid recipients who would otherwise seek care in the emergency room.

While we support the provision in general, NACHC opposes the specific increases in cost sharing proposed here because, like the change proposed for prescription drugs, these revisions violate the terms of Section 1916A. Specifically, the Proposed Rule provides that states may impose an across-the-board $8 cost sharing charge for any recipient with family income at or below 150% FPL for non-emergency use of the ED. 78 Fed. Reg. at 4703. However, the statute specifically sets different cost sharing levels for individuals with family income between 100% and 150% FPL, who are not statutorily exempt from cost sharing ("twice the amount determined to be nominal"); and for those with family income below 100% FPL, or who are statutorily exempt from cost sharing ("a nominal amount"). SSA § 1916A(e)(2)(B).

Congress clearly elected to authorize greater cost sharing burdens on the former category, on the ground that this category of recipients has higher family income and does not include certain vulnerable groups. The Proposed Rule violates the terms of the statute by authorizing twice the nominal copayment for a group whose cost sharing obligation is capped at the nominal amount.

Recommendations: NACHC recommends that CMS adhere to Congress' intent to impose lower cost sharing burdens on those with income below 100% FPL or who are statutorily exempt from cost sharing. Co-payments for this group should not exceed $4, the "nominal" amount set forth in the Proposed Rule for other outpatient services.

In addition, in subsection (c), there appears to be a typographical error: the reference to "paragraph (a) of this section" should instead be to "subsection (b) of this section."

NACHC also recommends that CMS clarify subsection (d) (2) of the proposed regulation. In this subsection, setting forth the procedures for a hospital ED to follow before imposing cost sharing for non-emergency use of the ED, *see* 78 Fed. Reg. at 4703, some steps in the procedure set forth in the statute are not included in the Proposed Rule. The omitted steps include the obligation of the ED to inform the recipient that a determination has been made that he or she does not have an emergency medical condition, and to notify the recipient of the applicable cost sharing for treatment of a non-emergency condition in the ED. *See* SSA § 1916A(e)(1)(B).

We recommend that CMS include the full requirements as set forth in the statute. Adequate notice to the patient is critical, given the significant cost sharing obligations triggered under Section 1916A and the Proposed Rule by non-emergency use of the ED.

4. **Proposed 42 C.F.R. § 447.56 (Limitations on premiums and cost sharing)**

NACHC proposes that CMS consider clarifying several aspects of proposed 42 C.F.R. § 447.56, which gathers scattered provisions in the current regulations limiting states' authority to impose cost sharing.

a. Comparability requirement

Subsection (b) provides, "Except as permitted under § 447.52(c) (targeted cost sharing), the agency may not exempt additional individuals from cost sharing obligations that apply generally to the population at issue." Section 447.52(c), in turn, permits such "targeted cost sharing" only for individuals with family income above 100% FPL. CMS explains the provision as follows in the preamble:

> At § 447.56(b), we propose to codify the existing statutory requirement to ensure comparability, such that states may not exempt additional populations from cost sharing, except in the case of targeted cost sharing. . . .

78 Fed. Reg. at 4661. As noted above, we do not believe that the comparability requirement would permit a state to impose cost sharing on one group of categorically needy recipients but not another.

Recommendation: NACHC recommends that CMS delete the first phrase of proposed 42 C.F.R. § 42 C.F.R. 447.52(c) (referencing the exception from comparability for "targeted cost sharing"), and that it delete proposed 42 C.F.R. § 447.52(c).

b. Application of cost sharing requirements to managed care

CMS noted in the preamble to the Proposed Rule that "[a]ny cost sharing included in the state plan would be applied equally to services provided under fee-for-service, managed care, or benchmark coverage." 78 Fed. Reg. at 4661. However, the Proposed Rule omits (without explanation) the present 42 C.F.R. § 447.60, which applies the requirements set forth in Part 447 to services provided under managed care: "Contracts with MCOs must provide that any cost sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost sharing charges imposed by the State agency."

Recommendation: NACHC recommends that CMS restore this provision to the regulations. If CMS deleted the provision solely because CMS considers this requirement to be imposed independently in 42 C.F.R. Part 438, we request that CMS clarify that point in its Final Rule.

c. **Payments to providers; payments to states**

NACHC recommends that CMS make revisions to the provisions of the Proposed Rule at 42 C.F.R. § 447.56(c) and 447.56(e), 78 Fed. Reg. at 4704, to take into account health centers' unique service obligations under Section 330 of the PHS Act.

These provisions, as set forth in the Proposed Rule, are substantially the same as the present regulations concerning the relationship among recipient cost sharing, provider payment, and federal financial participation. In particular, the state must reduce the amount of its payment to the provider by the recipient's cost sharing obligation, "regardless of whether the provider has collected the payment or waived the cost sharing," and no federal financial participation (FFP) in the state's expenditures for services is available for "any premiums of cost sharing amounts that recipients should have paid under §§ 447.52 through 447.55 (except for amounts that the agency pays as bad debts of providers under paragraph (a)(3) of this section[)]. . . ." 78 Fed. Reg. at 4704.

While recognizing that these provisions are not new, NACHC wishes to emphasize the new difficulties that they pose for health centers. As described above at pages 13-15 of these Comments, due to the combination of (1) the heightened cost sharing authorized under this Proposed Rule, (2) the health center's obligation to serve patients regardless of ability to pay, and (3) the rule under proposed 42 C.F.R. § 447.56(c) that the full cost sharing amount is automatically deducted from the state's payment for the service, health centers will likely be forced to accept inadequate reimbursement whenever Medicaid cost sharing exceeds the applicable patient payment responsibility under the health center's Section 330-compliant policies. (The potential for this conflict occurring would be mitigated if CMS establishes $4 as the across-the-board maximum cost sharing for FQHC services, as recommended above at page 12; and revises co-payments for prescription drugs as recommended above at page 16.)

In 2010, when CMS originally promulgated regulations implementing DRA 2005, commenters objected to the bar in the regulations on state payment for cost sharing amounts that were waived or reduced by the provider. They noted that the burdens on providers inherent in this policy were aggravated by the new flexibility to impose higher cost sharing under DRA 2005. CMS replied that "[t]he requirement that States not reimburse providers for unpaid cost sharing is a longstanding Medicaid policy," 75 Fed. Reg. at 30,255, but did not cite any statutory basis for the requirement.

Recommendations: Since the rule set forth at proposed 42 C.F.R. § 447.56(c) has no statutory basis, and since it will result in inadequate payment to health centers, NACHC urges CMS to add to the regulation an exception, which would entitle FQHCs to full Medicaid payment in situations where they are required under their Section 330 grants to waive a portion of the Medicaid cost sharing. Specifically, we recommend that CMS add a sentence to § 447.56(c)(3), to read as follows (addition italicized):

> For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers. F*or an FQHC, as defined at Section 1905(l)(B)(2) of the Act, an agency shall increase its payment to offset cost sharing that has been waived or reduced in accordance with the FQHC's obligations under Section 330 of the Public Health Service Act.*

We recommend a conforming revision to proposed 42 C.F.R. § 447.56(e)(1) (addition italicized). As revised, the paragraph would provide that no FFP is available for "(1) [a]ny premiums or cost sharing amounts that recipients should have paid under § 447.52 through

447.55 (except for amounts that the agency pays as bad debts of providers under paragraph (a)(3) of this section, *and except for amounts claimed by FQHCs as waived or reduced cost sharing pursuant to paragraph (a)(3)).*"

5. HHS waiver of cost sharing requirements

The Proposed Rule does not address the scope and authority of waivers of the cost sharing requirements imposed under Sections 1916 and 1916A and 42 C.F.R. Part 447, Subpart A. Moreover, the Proposed Rule (without explanation) omits the existing regulation addressing this issue, which provides: "Waivers of the limitations described in this subpart on deductions, cost sharing, and similar charges may be granted only in accordance with the provisions of section 1916(f) of the Act." 42 C.F.R. § 447.62(b). CMS did not include any discussion of this issue in the preamble to the Proposed Rule.

Section 1916(f), as amended by DRA 2005, provides that with the exception of certain waivers specifically authorized under Sections 1916 and 1916A, no waiver pertaining to cost sharing may be imposed under the Secretary's authority unless it meets five criteria set forth in the statute. Among these criteria, the demonstration must be "limited to a period of not more than two years" and must be "voluntary, or make[] provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation." SSA § 1916(f)(2), (5). The criteria for granting a Section 1916(f) waiver and the terms of the waiver are thus substantially narrower than the corresponding criteria and terms for Section 1115 demonstrations. CMS stated in the 2010 preamble to the cost sharing regulations, "In light of Section 1916A of the Act and the provision of the DRA that applies section 1916(f) to the Act, we are reviewing our policies under section 1115 of the Social Security Act." 75 Fed. Reg. at 30,249.

Recommendations: NACHC requests that CMS reinstate 42 C.F.R. § 447.62(b) and make clear that for Medicaid recipients covered under the state plan, Section 1916(f) is the only authority for the Secretary to waive requirements in Sections 1916 and 196A relating to premiums or cost sharing. In addition, we recommend that CMS update 42 C.F.R. § 431.57 (waiver of cost-sharing requirements) to reflect that the requirements at SSA § 1916(f) apply to any waiver of the cost sharing requirements set forth in SSA § 1916A.

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Thank you for the opportunity to comment on the Proposed Rule. Please do not hesitate to contact me by telephone at (202) 296-0158 or by e-mail at rschwartz@nachc.org if you require any clarification on the comments presented above.

Sincerely,

Roger Schwartz
Associate Vice President of Executive Branch Liaison