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Via email to CHFSregs@ky.gov

May 31, 2019

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Office of Legislative and Regulatory Affairs
275 East Main Street 5 W-A
Frankfort, KY 40621

Re: Comments on new regulation regarding Medicaid recipient cost-sharing:
Title 907 KAR 1:604. Recipient cost-sharing.

As drafted, 907 KAR 1:604, regarding recipient cost-sharing, would cause harm to both Medicaid members and medical providers. Copays are a barrier for members accessing services and an administrative and financial burden for providers. Additionally, the variations in copay requirements for different populations at different times cause unnecessary confusion among members and restrict members' use of needed medical services.

As a Medicaid application assister with Kentucky Equal Justice Center, I have been assisting low income people to enroll in Medicaid for the last five years, but access to care does not always magically take shape after enrollment. I also help members navigate the Medicaid system and advocate for themselves once they have coverage. Here I share my perspective on how Medicaid members experience copays. I amend and resubmit my comments as previously submitted via email on February 26 and regarding the original regulation. My amended comments include additional testimony shared as requested by Medicaid member Diann Newcomb.

Since Kentucky Medicaid moved to Managed Care Organizations (MCOs) several years ago, copays have been in effect. However, the state previously gave MCOs the option to charge within an allowed range of copays or waive copays completely. The MCOs chose not to collect the copays because of the administrative burden of collecting them and the harm that copays cause to Medicaid members. This is market wisdom. Charging copays does not increase revenues for providers or MCOs. Rather, copays discourage and restrict members from accessing services, resulting in ineffective Medicaid coverage and negative health outcomes.

There are two important protections built into the copay policy according to the Department for Medicaid Services. However, neither of these protections are mentioned in the regulations. Additionally, these protections are complicated for the state to track and for the provider and MCOs to administer. It is difficult to communicate these rules to Medicaid members, who are left not knowing their rights nor how to budget for copayments.

Consider one of the protections: that if an individual has paid 5% of their income on copays in a quarter, providers cannot collect the copay for the remainder of the quarter. I have been helping Medicaid members enroll since 2014. Many of them continue to come to me with questions, problems, and to seek help renewing their Medicaid. Since copays were temporarily made mandatory in July 2018, and are again mandatory as of January 2019, many of these members have contacted me in confusion about cost-sharing. Even if they can afford to pay copays some of the time, if they are charged a copay for a service one month and not the next, the result is that members are uncertain how to budget for their medical expenses. In a household with limited income, budgeting is crucial. It may be that the member receives disability payments, that they applied for disability but have not received payments yet, that they work, but have to work limited hours because of a health condition, or they are supporting multiple other family members while working one or two low wage jobs. If their copay charges for a quarter reach 5% and they are subsequently exempted from copays for their medication in February and March, then they may not know that they need to budget to pay the copay again at the start of a new quarter in April. If they don't have the cash when they show up at the pharmacy, the pharmacy turns them away. Their access to necessary medication is delayed and they may have difficulty coming up with the cash, causing them to skip medication doses. This scenario is especially detrimental to anyone trying to manage a chronic mental health condition for which medication effects accumulate over weeks and may be drastic.

Consider DMS's other protection: that individuals under 100% of Federal Poverty Level cannot be turned away from services if they are unable to pay the copay, though providers must attempt to collect it. While this protection, too, is well-intended, it is difficult for providers to administer. Both providers and consumers understand that Medicaid is a set of benefits and coverage within a network. When those benefits are different for various types of Medicaid members, it becomes very confusing. Medicaid members do not know their percentage of Federal Poverty Level, but rely on providers to charge them correctly. And since a provider must attempt to collect a copay regardless, their initial attempt may scare members away from utilizing necessary services. This scenario often results in the same complications of missed medications and treatments mentioned previously. A Medicaid member was referred to me in early February seeking urgent help--he had been going without his Invega injection for two months. He was very anxious, repeating his problem over and over so that I had to interrupt him to try to help him. It turns out that Invega is an antipsychotic that he needed to help manage his bipolar. His pharmacy was trying to charge him $3 for the shot and he could not pay. This man was under 100% Federal Poverty Level and on a fixed income. $3 may not seem like a lot, but it was having a huge impact on his life and his

interactions with people around him. I think that because he is under 100% FPL, he should never have been charged this fee, but this is the reality people confront under the new policy.

Diann Newcomb had a similar experience. I first spoke with her on April 4 of this year after she had called frantically seeking help. Ms. Newcomb's family of four is under 100% FPL. In late March, Ms. Newcomb's pharmacy in Campbellsville began refusing to give her needed prescriptions without her paying the copays. The pharmacy charged her $1 for Tama flu and $5 for Tylenol 3, Zofran, and Amoxicillin. Since she does not have money, she stretched her Losartan medication for blood pressure by quartering the pills and stretched her diabetes test strips by using one every four days, so that she could put off buying more. Her pharmacist explained to her that the Department for Medicaid Services urged that they charge copays to every Medicaid member regardless of income. Her pharmacist told her, "no copays, no medicine." However, given her income level and DMS's policy regarding households below 100% FPL, Diann's pharmacy was not permitted to deny her prescriptions even if she could not pay the copays. It took multiple contacts with the pharmacy and a formal letter from DMS before the pharmacy began complying. By that time, Diann had already suffered additional stress, anxiety, and expense, and had rationed her care, which may have long-term health effects. Even when policy protected Diann, it was difficult and confusing for the provider to implement, which caused harm.

Even now that Diann's pharmacy is complying with DMS policy and is supplying her medications despite her inability to pay the copay, Diann is still concerned about having to pay. This cost sharing regulation states that:

> (5) Any amount of uncollected copayment by a provider from a recipient shall be considered a debt to the provider. (6)[(a)] A provider shall: (a) [1.] Collect from a recipient the copayment as imposed by the department for a recipient in accordance with this administrative regulation; (b)[2.] Not waive a copayment obligation as imposed by the department for a recipient; and (c)[3.] Collect a copayment at the time a benefit is provided or at a later date.

The regulation is not clear. It is small comfort for people like Diann. Even if she can access her medications today, five dollar copays add up over several medications and several months. If the pharmacy is allowed to bill her and sell her debt to debt collectors, she could be hounded for that money months later. Besides this debt causing further stress to patients like Diann, it is squeezing blood from a turnip. Someone under 100% Federal Poverty Level doesn't have the money to begin with, so why bill them? The regulation should prohibit providers (including pharmacies) from collecting on copays after the service date for members under 100% FPL. I am requesting that the regulation be modified to protect members under 100% from this kind of stress and financial strain. Even if the member's income goes above 100% FPL after the date of service, their economic state is most likely not stable enough to milk them for money.

I am also concerned about individuals like the two mentioned above, but who may be above 100% FPL at the time of service and therefore unprotected by this DMS policy of not refusing services. These are people who have severe health conditions that would meet the qualifications of “medically frail” under the Kentucky HEALTH waiver. These members interact frequently with health care providers and will have high out-of-pocket expenses. With or without Kentucky HEALTH, the state can assess and determine “medically frail”, and exempt these individuals from copays. However, “medically frail” individuals are not exempt from copays in this regulation. This failure to protect “medically frail” members puts them at increased risk of being unable to access their critical health services.

As written, the cost-sharing regulations do not protect “medically frail” members, members under 100% FPL, or members who have already contributed 5% of their income towards copays in a quarter. Regardless, copays are not an effective tool for administering health care. Copays harm consumers and burden providers and MCOs. Please consider these my updated comments during review of Title 907 KAR 1:604. Accordingly, please send me a copy of the Statement of Consideration in response to my comments. Thank you for your consideration.

Sincerely,

Miranda Brown
Certified Application Counselor for Medicaid and Marketplace health coverage