Medicaid and CHIP MAC Learning Collaboratives

Expanding Coverage Learning Collaborative

Implementing Medicaid/CHIP Cost-Sharing Tracking: Federal Requirements and State Experiences

February 25, 2016
3:00-5:00 pm ET

Agenda

- Setting the Stage and Project Approach
- Cost-Sharing Tracking Requirements
- Findings From State Interviews
- Lessons Learned and Discussion Part 1
- Lessons Learned and Discussion Part 2

Setting the Stage and Project Approach

Setting the Stage

- CMS issued streamlined and consolidated cost-sharing and premium regulations in July 2013 implementing SSA §§ 1916 and 1916A. Regulations became effective January 1, 2014. (See Appendix)
- To conform with revised regulations, CMS issued new Cost Sharing State Plan Amendment (SPA) templates.
- Enhanced 90/10 funding for MMIS gives states an opportunity to build systems that can track incurred copayments and premiums against the cost-sharing cap in compliance with federal rules.
- Many states have sought guidance from CMS on strategies and approaches for implementing a successful cost-sharing tracking infrastructure.

CMS-2334-F, "Medicaid and Children Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchange: Eligibility and Enrollment; Final Rule" (July 15, 2013); CMS-2392-F, "Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10)" (December 4, 2015).

Project Approach

- Review federal regulations, guidance and Cost Sharing State Plan Amendment related to copayment and premium requirements.
- Interview states about their implementation of copayment and premium tracking.
- Build on the Cost Sharing Coverage Learning Collaborative (LC) held in 2014, to identify potential solutions for building effective tracking systems.
  - Overview of federal premium and cost sharing requirements in Appendix to slide deck
  - Link to 2014 Cost Sharing LC slides can be found at link

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Cost-Sharing Tracking Requirements

Cost Sharing Aggregate Limit Requirements

- Medicaid premiums and cost sharing **incurred by all individuals in the Medicaid household may not exceed an aggregate limit of 5 percent of** the family's income applied on a quarterly or monthly basis.
- If the state imposes premiums or cost sharing that could place beneficiaries at risk of reaching the aggregate family limit, the State Plan must indicate **a process to track each family's incurred premiums and cost sharing through an effective mechanism** that does not rely on beneficiary documentation.
- The agency must inform beneficiaries and providers of the beneficiaries aggregate limit and **notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit** and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

42 C.F.R. 447.56(f)(1),(2),(3)

Throughout this presentation "family" is defined as the Medicaid/CHIP household

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CHIP Cost Sharing Aggregate Limit Requirements

- A State **may not** impose premiums, enrollment fees, copayments, coinsurance, deductibles, or similar cost-sharing charges that, in the aggregate, **exceed 5 percent of a family's total income for the length of a child's eligibility period in the State**.
- The State **must inform** the enrollee's family in writing, and orally if appropriate, of their individual **cumulative cost-sharing maximum amount at the time of enrollment and reenrollment**.
- Automated tracking of incurred cost sharing is not required in CHIP.

42 C.F.R. 457.560

Tracking Premiums and Cost Sharing Against 5% Cap

Tracking System

- States have the obligation to track the amount of copayments and premiums *incurred*, not just amount paid.
- State agency must inform beneficiaries and providers of the beneficiaries' limit and notify both when the aggregate limit has been reached for each beneficiary, and then "turn off" cost-sharing.
- States are required to reduce the claimed provider payments for purpose of the FFP by the amount of the cost sharing obligation, regardless of whether the provider or State collects the copayment.
- States must have a process in place for beneficiaries to request a re-assessment of their household aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium.
- When a beneficiary is charged cost-sharing that exceeds his or her limit, states must have a reimbursement process in place (but may not exclusively rely on a system that reimburses beneficiaries rather than turning off cost-sharing at cap).

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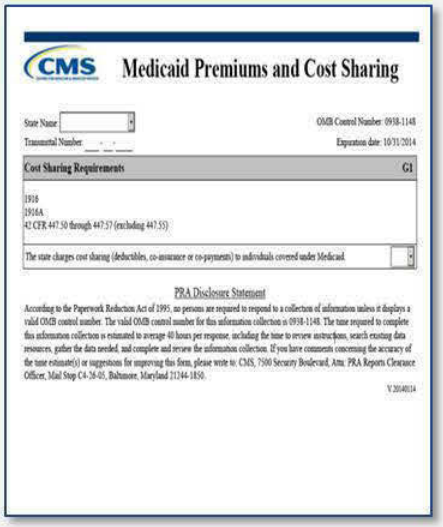
SSA § 1916A(b)(1)(B)(ii), (b)(2)(A); 42 CFR § 447.56(f); 78 Fed. Reg. 42160, 42282-83 (July 15, 2013); Cost Sharing SPA Template, Section G3.

Requirements of a Cost Sharing State Plan Amendment

- Since January 1, 2014, states are required to update their cost-sharing on the "new" MMDL SPA templates.
- In addition to information about populations to be charged and services which are subject to cost-sharing, the new cost-sharing SPAs have the following cost-sharing tracking requirements:
  - Percentage of household income used for the aggregate limit (e.g. 5%)
  - Whether the state tracks on a quarterly or monthly basis
  - Affirmation that the state has a process in place to track incurred premiums and copayments through a mechanism that does not rely on beneficiary documentation (aka "shoebox method")
  - Affirmation that the state has a documented appeals process for families that believe they incurred cost sharing above the aggregate limit
  - Description of the process used to reimburse beneficiaries and/or providers if the household is identified as paying over the cap
  - Description of the process for beneficiaries to request a reassessment of their household aggregate limit



CMS Medicaid Premiums and Cost Sharing

State Name:

Transmittal Number:

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

Cost Sharing Requirements	G1
1916 1916A 42 CFR 447.50 through 447.57 (excluding 447.55)	
The state charges cost sharing (deductibles, co-assurance or co-payments) to individuals covered under Medicaid.	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140114

Findings From State Interviews

State Interview Selection

Geography & Population

- States with different sizes of Medicaid and CHIP populations

Medicaid and CHIP

- Interviewed states represent processes for both Medicaid and CHIP cost-sharing tracking

Vendors and Functionality

- States use different eligibility and enrollment and MMIS vendors
- States are at different stages in their timeline for implementing cost-sharing tracking

Delivery System Model

- States utilize a mix of fee-for-service and managed care arrangements

Lessons Learned and Discussion Part 1

Components of the Cost-Sharing Tracking Process

Constructing a Household and Calculating Income for Purposes of Determining the 5% Aggregate Household Cap

Assigning the 5% Aggregate Household Cap

Tracking Incurred Copayments and Premiums of Each Household Member Against the 5% Cap

Coordinating with Providers

Coordinating with Beneficiaries

Constructing a Household and Calculating Income for Purposes of Determining the 5% Aggregate Household Cap

Constructing a Household and Calculating Income

- In all interviewed states, the Eligibility and Enrollment (E&E) System constructs a MAGI household for each individual and verifies household income for several purposes, including determining the 5% aggregate household cap. (*Georgia, Michigan, West Virginia*)

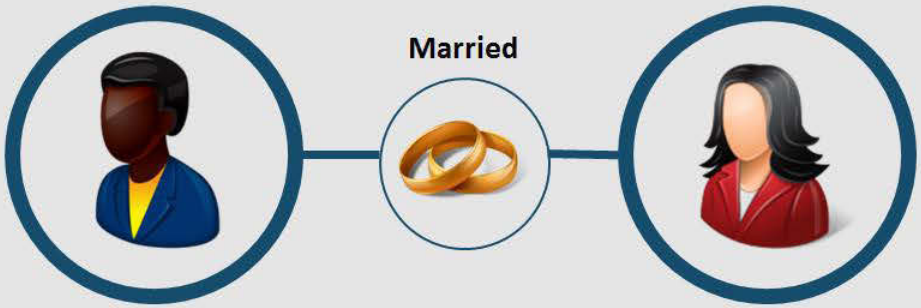
Household composition for purposes of determining eligibility = **Household composition for purposes of calculating 5% aggregate household cap**

- Each household member is assigned a cost-sharing cap based on his or her household size and income.

- In some-households (e.g., MAGI and non-MAGI; filers and non-filers), each individual within the household may have a different household size and income.
  - As a result, an individual could have a cost-sharing cap that is different from other members of the household.

Cost-Sharing Tracking Scenario #1

Meet the Smith family. Joe and Jane Smith are married, live together and file taxes jointly.



Joe and Jane file taxes jointly

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Scenario #1: MAGI Household Composition, Income and Caps

Joe and Jane are in the same household and have the same cost-sharing cap

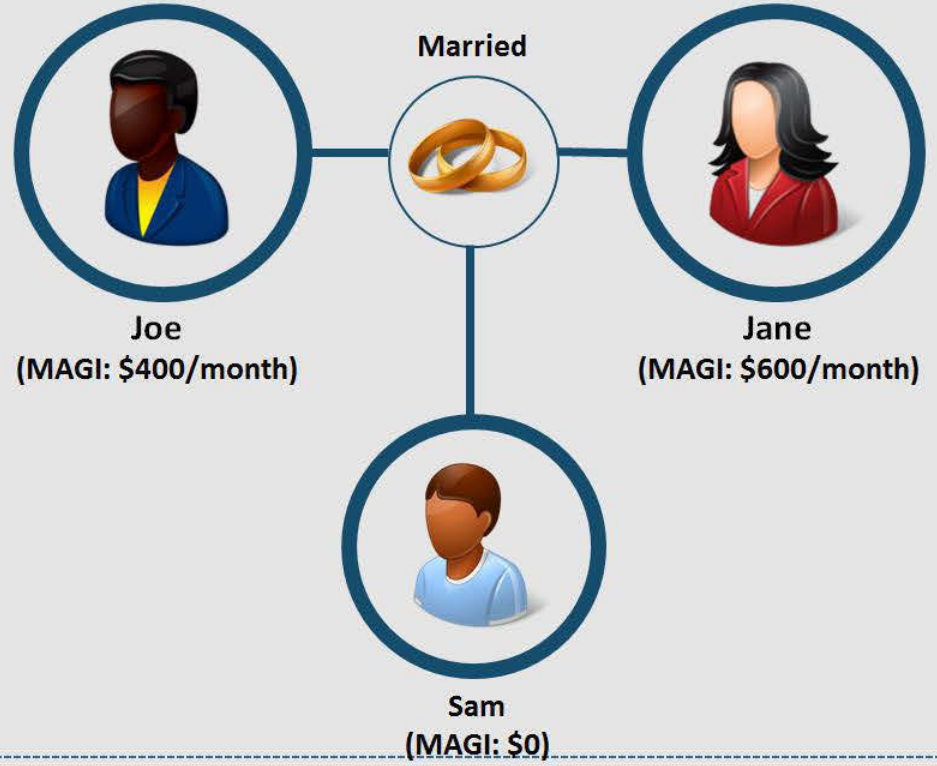
Joe's Household (HH)	Jane's Household
 • **HH Members: 2.** Joe + Jane • **HH Income**: $1,000/month (Joe+Jane's income) • **HH Monthly Copayment Cap:** $50/month (5% of $1,000)	 • **HH Members: 2.** Joe + Jane • **HH Income**: $1,000/month (Joe+Jane's income) • **HH Monthly Copayment Cap:** $50/month (5% of $1,000)

States must track incurred copayments against the 5% cap across the entire Smith household. Let's assume a state were tracking the cap on a monthly basis:

- When Jane visits the hospital, she incurs a copayment of $15. The amount remaining under Jane's monthly aggregate copayment cap is decreased by $15. Jane's remaining monthly copayment cap is now $35 ($50-$15).
- The amount remaining under Joe's aggregate copayment cap must also be decreased by $15 because Jane is part of Joe's household. Joe's remaining copayment cap is also $35 ($50-$15).
- If Joe incurs a copayment in the same month of $5, both Jane and Joe's remaining copayment cap is reduced to $30 ($35-$5).
- In a household with the same cost sharing obligation, if one person hits the cap the entire family hits the cap.

Cost-Sharing Tracking Scenario #2

Meet the Smith family. Joe and Jane Smith are married, live together and file taxes jointly. They are the biological parents of Sam (age 10) and they claim Sam as a tax dependent.



Joe and Jane file taxes jointly

They claim their son, Sam, as a tax dependent

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Scenario #2: MAGI Household Composition With Child

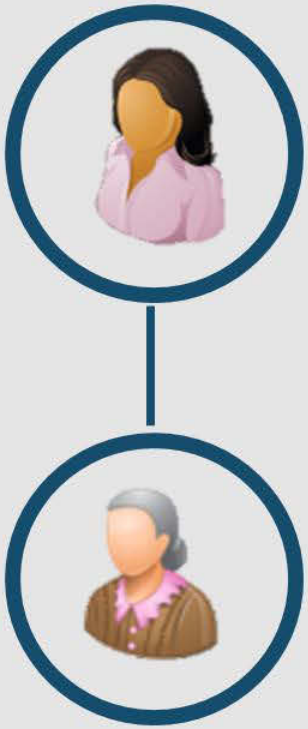
Joe and Jane are in the same household and have the same cost-sharing cap. Sam is a child and is not subject to co-payments.

Joe's Household (HH)	Jane's Household (HH)	Sam's Household (HH)
 • **HH Members: 3.** Joe + Jane + Sam • **HH Income**: $1,000/month (Joe+Jane's income) • **HH Monthly Copayment Cap:** $50/month (5% of $1,000)	 • **HH Members: 3.** Joe + Jane + Sam • **HH Income**: $1,000/month (Joe+Jane's income) • **HH Monthly Copayment Cap:** $50/month (5% of $1,000)	 • **HH Members: 3.** Joe + Jane + Sam • **HH Income**: $1,000/month (Joe+Jane's income) • **HH Monthly Copayment Cap:** No cost sharing obligation = $0

- When Jane visits the hospital, she incurs a copayment of $15. The amount remaining under Jane's monthly aggregate copayment cap is decreased by $15. Jane's remaining monthly copayment cap is now $35 ($50-$15)
- The amount remaining under Joe's aggregate copayment cap must also be decreased by $15 because Jane is part of Joe's household. Joe's remaining copayment cap is also $35 ($50-$15).
- Jane's incurred co-payments do not impact Sam because Sam is a child and has no cost sharing obligations.

Cost-Sharing Tracking Scenario #3

Meet the Jones family. Maria Jones lives with her Aunt Joanne (66 y/o).



Maria (MAGI: $500/month in earned income)

Jane's Aunt, Joanne (Non-MAGI: $300/month in unearned Income)

- ✓ Maria claims her Aunt Joanne as a tax dependent
- ✓ Aunt Joanne is over age 65 and eligible under non-MAGI rules
- ✓ Aunt Joanne's income is over the tax filing threshold

Scenario #3: MAGI/Non-MAGI Household Composition, Income and Caps

Maria and Joanne have different household compositions and cost-sharing caps

Maria's Household	Joanne's Household
 • **HH Members: 2.** Maria + Joanne • **HH Income:** $800/month (Maria + Joanne's income) • **HH Monthly Copayment Cap:** $40/month (5% of $800)	 • **HH Members: 1.** Joanne only • **HH Income:** $300/month (Joanne's income) • **HH Monthly Copayment Cap:** $15/month (5% of $300)

Joanne's incurred cost-sharing counts toward Maria's cap, but Maria's incurred cost-sharing does not count toward Joanne's cap because Maria is not counted in Joanne's household.

- When Aunt Joanne visits the hospital she incurs a copayment of $15. The amount remaining under Aunt Joanne's monthly aggregate copayment cap will be decreased by $15. Aunt Joanne's remaining monthly copayment cap is now $0 ($15-$15).
- Maria's aggregate copayment cap must also be decreased by $15 because Aunt Joanne is part of Maria's household. The amount remaining under Maria's copayment cap is now $25 ($40-$15).
- If Maria incurs a $10 copayment, that amount is subtracted from Maria's cap but not from Joanne's cap because Maria is not in Joanne's household.

Constructing a Household: Key Takeaways

- Household composition for the purposes of determining eligibility is the same as household composition for purposes of calculating the 5% aggregate household cap.
- Each household member's incurred cost-sharing (premiums and copayments) must be counted against the cap of all the other household members in the member's household.
- In some circumstances, individuals living together may be in different MAGI households and therefore may have different household sizes, incomes and cost-sharing caps.

Discussion

Assigning the 5% Aggregate Cap

Systems Used to Calculate the 5% Aggregate Household Cap

- In all interviewed states, MMIS is the system that calculates and assigns the 5% aggregate cap based on household size and income sent from E&E system. (*Georgia, Michigan, West Virginia*)

- If a state establishes a nominal copayment structure and demonstrates to CMS that it is very unlikely that beneficiaries will reach the cap, no tracking system is required.
  - *Example*: State applies $.50 copayments for all services to individuals with incomes > 100% FPL.

Calculating the 5% Aggregate Household Cap

- Two interviewed states assign the actual 5% household income cap for each individual. *(Georgia and Michigan)*

Joe's Household

- **HH Members: 2.** Joe + Jane
- **HH Income**: $1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** $50/month (5% of $1,000)

Jane's Household

- **HH Members: 2.** Joe + Jane
- **HH Income**: $1,000/month (Joe+Jane's income)
- **HH Monthly Copayment Cap:** $50/month (5% of $1,000)

Calculating the 5% Aggregate Household Cap

- One interviewed state identifies household income, compares income against a set of Tiers and charges a flat copayment for each Tier. *(West Virginia)*

Example: A state could calculate a copayment cap amount based on the lower end of an income range within a Tier and use a household of one.

Tier	Copayment Limit
Tier 1 (0-50% FPL)	$0/month
Tier 2 (51-100% FPL)	$24/month (Cap amount based on 5% of 51% of the FPL for a household of 1)
Tier 3 (101-138% FPL)	$50/month (Cap amount based on 5% of 101% of the FPL for a household of 1)

Jane and Joe's Household Income = $1,000/month
= 102% FPL

HH Monthly Copayment Cap: $50/month (Tier 3)

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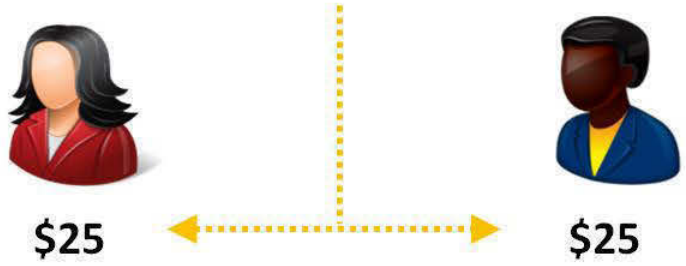
Alternative Approaches to Calculating the Cap

A state could allocate the cap amount by pro-rating the 5% cap across all household members. State would no longer need to aggregate incurred copayments across household members.

Joe and Jane's Household

Joe and Jane each have a household cap of **$50/month**



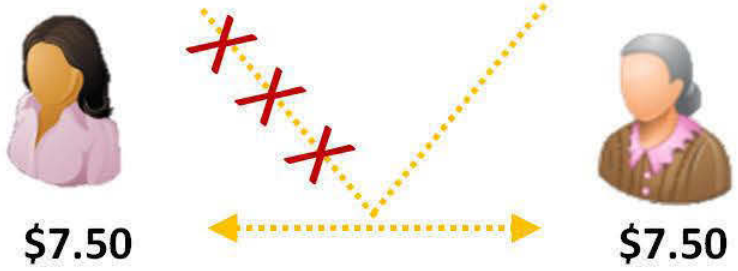
A state could divide the household cap evenly across household members so Joe and Jane have a cap amount of $25/month each.

Example 1

Maria's and Joanne's Households

Maria has a household cap of **$40**

Joanne has a household cap of **$15**



A state could divide the household cap evenly across household members based on the *lower* household cap amount. Each individual's cap is $7.50.

Example 2

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Discussion

Tracking Incurred Copayments and Premiums of Each Household Member Against the 5% Cap

Tracking Incurred Copayments of Each Household Member

A cost-sharing tracking system must have functionality to track incurred cost sharing against the 5% aggregate cap

Tracking Across Household Members

Systems must track incurred copayments and premiums across multiple members of a household

Tracking Incurred Copayments of Each Household Member

Tracking Across Household Members

States are required to track cost-sharing incurred by all members of the household and attribute cost-sharing across household members. However, most MMIS process claims at the individual level and are not programmed to aggregate claims at the household level.

The most common approach to tracking cost-sharing at the household level:

- Build functionality in the MMIS that assigns a **Cost-Sharing ID (may also be referred to as a Household ID)** to each individual and tracks cost-sharing as claims are processed. The Cost-Sharing ID number can attribute expenditures and incurred cost-sharing across multiple household members. (*Georgia, Michigan, West Virginia*)

Tracking Incurred Copayments of Each Household Member (cont'd)

Tracking Across Household Members

Alternative Approach for Discussion:

- For states that do not have the systems capacity to assign a Cost-Sharing ID, an **alternative proposed approach** (work-around for a legacy system) is to utilize an MMIS Data Warehouse Decision Support System.
- At the end of the month or quarter, the MMIS would run claims reports; calculate the cost-sharing that would have been applicable to each claim; and aggregate claims for each member of the household.
- This approach may require more extensive transfer of data and coordination across IT systems, which could make tracking less timely than the MMIS cost-sharing ID approach.

Tracking Incurred Copayments of Each Household Member

Cost Sharing ID Example*

Maria's Household

- **HH Members:** 2. Maria + Joanne
- **HH Income:** $800/month (Marie+Joanne's income)
- **HH Monthly Copayment Cap:** $40 (5% of $800)

Cost-Sharing ID #: 5278

Joanne's Household

- **HH Members:** 1. Joanne only
- **HH Income:** $300/month (Joanne's income)
- **HH Monthly Copayment Cap:** $15 (5% of $300)

Cost-Sharing ID #: 5279

- Maria's incurred copayments are assigned to **Cost-Sharing ID # 5278** (Maria's household) only.
- Joanne's incurred copayments are assigned to **Cost-Sharing ID #5278** (Maria's household) *and* **Cost-Sharing ID #5279** (Joanne's household).
- Incurred copayments are deducted from the total cost sharing liability for each respective cost sharing ID

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* This is a simplified example and does not represent the variety of ways that states may track incurred cost-sharing across household members.

Discussion

Wrap Up

Next SOTA Meeting: March 24, 1:30-2:30 pm ET

Part 2: Cost Sharing Discussion

- Tracking frequency and timeliness
- Copayment collection considerations
- Tracking across delivery systems
- Coordinating with providers
- Communicating with consumers
- Reimbursement approaches

Lessons Learned and Discussion Part 2

Tracking Frequency Options

State must choose how frequently to track and attribute incurred copayments and premiums to a household

State must also turn off cost-sharing when cap is reached and reset the cap at appropriate time

Tracking Timeframes: Monthly, Quarterly or Annually

Timeframe for Calculating the Cap

Medicaid: States may choose to calculate the aggregate cap on a monthly or quarterly basis. A state's decision impacts the size of the cap.

- *Example*: An individual's monthly household income is $1200.
  - Aggregate monthly cap: $60
  - Aggregate quarterly cap: $180
- Two interviewed states calculated Medicaid cost-sharing against a quarterly cap. (*Michigan, West Virginia*)

CHIP: States may calculate the aggregate cap on an annual basis. (*Georgia*)

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Frequency When Subtracting Incurred Cost Sharing Cap

Tracking Frequency

States have flexibility to determine how frequently they will subtract incurred cost sharing (copayments and premiums) against the household aggregate cap.

Interviewed states' approaches towards subtracting incurred cost-sharing varied:

- One state subtracts cost-sharing in real time (subject to provider claims submission). (*Michigan fee-for-service)*
- Two interviewed states subtract incurred cost-sharing on a monthly basis. *(Georgia, West Virginia).* This means the state tallies up the incurred cost sharing at the end of the month.
    - Tracking on a monthly basis may require reconciliation for beneficiaries who exceed their 5% cap and continue to incur copayments.
    - To prevent beneficiaries from exceeding the cap between monthly reconciliations, Georgia tracks against an aggregate cap of 4.5%.

Claims Lag Considerations. Cost-sharing cannot be assigned to a household until a claim is submitted by a provider. In many states, providers have up to a year to submit claims. Delays in provider billing may result in individuals actually hitting their 5% cap but continuing to incur cost-sharing. When this happens a process must exist to repay the excess cost sharing paid by the beneficiary.

Timing of Copayment Collection

Point of Service vs. Retrospective Billing

- In all interviewed states, providers collect copayments from beneficiaries at point-of-service. (*Georgia, West Virginia, Michigan for fee-for-service population)*

- CMS is currently evaluating the approach of collecting payments retrospectively currently being done under an 1115 Waiver Demonstration to determine whether to extend this flexibility under a State Plan Amendment.
    - Provider would need to inform the beneficiary at the point of service the amount that will be billed later to ensure the beneficiary has information needed to consent to care

Timing of Copayment Collection (cont'd)

State Implementation Considerations

Point-of-Service:

- Copayments paid in smaller increments
- Consumer embarrassment if it is difficult to make payment at point-of-service
- Potential denial of care for individuals with income > 100% FPL
- Greater potential for beneficiaries to exceed 5% cap due to delay in calculating cap because of provider claims lag

Retrospective billing:

- Copayments may be a larger amount which could be burdensome for consumers/unable to pay larger amount
- No denial of service for lack of payment but unpaid cost sharing may be considered a collectible debt
- Enrollees are less likely to exceed 5% cap because MMIS is able to subtract incurred copayment prior to charging beneficiary~~)~~
- State (or provider) would need operation / billing system infrastructure/ contract with vendor

Turning off Cost-Sharing When Cap is Hit

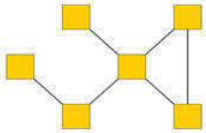
Required Functionality

- Tracking cost-sharing expenditures for beneficiaries requires a payment system to:
  - **store** the cost-sharing cap amount;
  - **subtract incurred cost-sharing premiums** until the cap amount is reduced to zero;
  - **reduce the payment to the provider** by the appropriate cost sharing amount (the lesser of the copayment or remaining cost sharing liability amount); and
  - **apply routine payment protocols** for claims received during the remainder of the cost sharing period.
- Systems would need to reset this process at the beginning of each new cost sharing period (monthly or quarterly).
- States that apply both premiums and copayments may wish to have the system deduct all premiums for the period prior to deducting copayments.

Discussion

Tracking Across Delivery Systems

A cost-sharing tracking system must have system functionality in a number of key areas



Systems must track incurred copayments across fee-for service and managed care arrangements and potentially across multiple managed care plans (or premium assistance plans) for households receiving care through different plans or systems

Tracking Across Delivery Systems

System Considerations

All interviewed states utilized a mix of fee-for-service and managed care arrangements. The system must track cost-sharing across:

- ✓ Households with some individuals enrolled in fee-for-service and others in managed care
- ✓ Household with individuals enrolled in different managed care plans
- ✓ Individuals that incur cost-sharing in managed care and fee-for-service (through managed care carve outs)

In states that are unable to aggregate incurred cost sharing across systems (*e.g.*, FFS and managed care), a state could apply one cap to the FFS system and one cap to managed care system; collectively the caps may not exceed 5%.

- *Example*: State applies a 2% cap for incurred services in FFS and a 3% cap for incurred services in managed care.

Tracking Across Delivery Systems (cont'd)

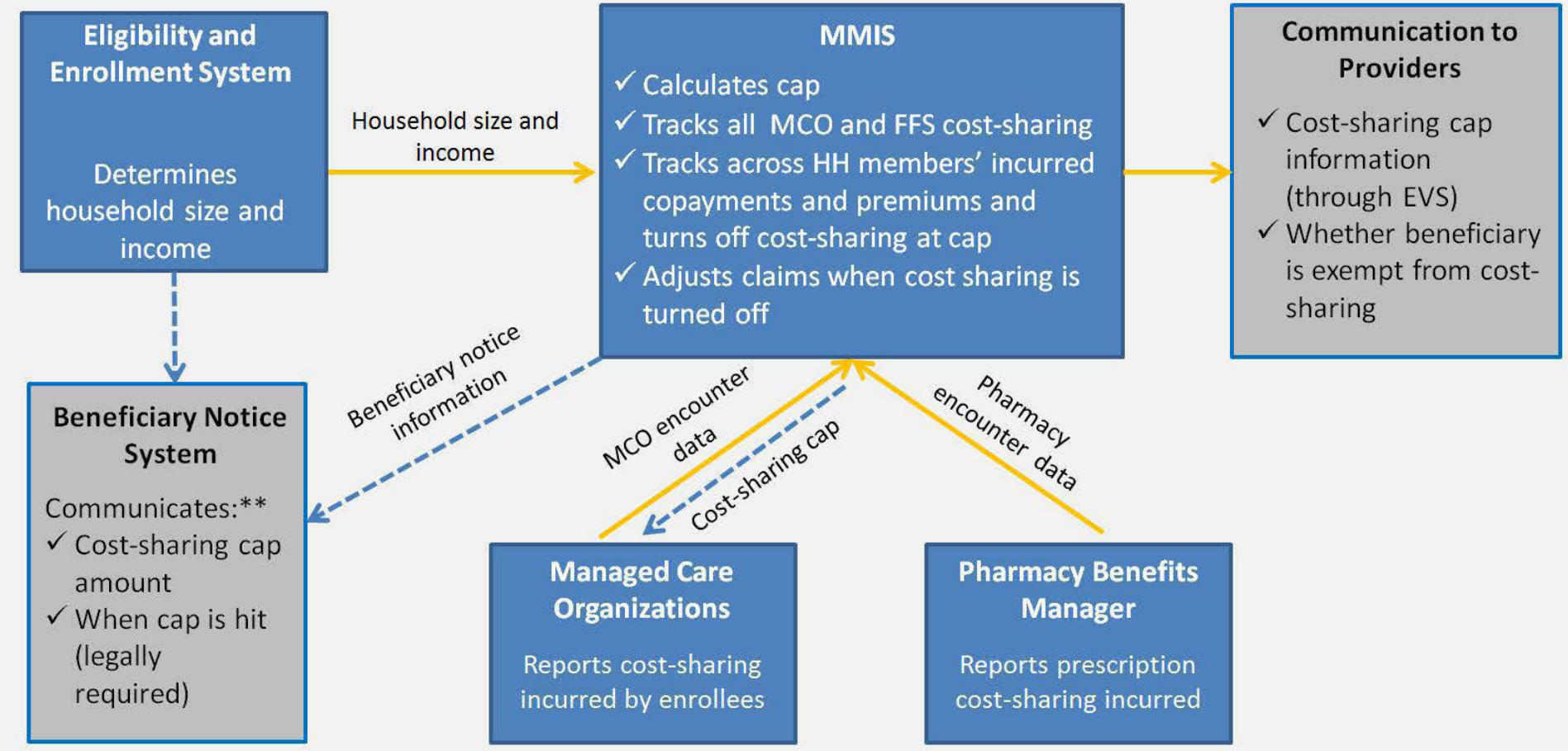
System Considerations

- In some interviewed states, a pharmacy benefits manager (PBM) tracks prescription cost sharing and reports to the State. *(Georgia and Michigan)*

- Tracking all household cost sharing requires coordination between State and MCO IT systems including:
  - Sharing each individual's household cap with MCOs (typically done by MMIS).
  - Tracking FFS expenditures for populations and services carved out of managed care (typically done by MMIS).
  - Communicating cost-sharing cap to providers (typically done by Eligibility Verification System within the MMIS).
  - Communicating with beneficiaries (typically done by E&E system, MMIS, and/or MCOs).

Tracking Incurred Copayments of Each Household Member: Example Process Flow*

Different IT systems interact throughout the tracking process



*Process flow is simplified and does not include all systems involved in the tracking process.
**System responsible depends on State.

Discussion

Coordinating with Providers

Coordinating with Providers

- In all interviewed states, providers access cost-sharing tracking information through an EVS portal at point of service. (*Georgia, Michigan, West Virginia*)

- In two interviewed states, the EVS portal displays beneficiary's cost-sharing cap information and indicates whether a beneficiary is exempt from copayments. (*Michigan, West Virginia*)
- In one interviewed state, the EVS portal displays whether beneficiary is eligible for CHIP and if cost-sharing should be assessed (Yes/No). (*Georgia*)

Coordinating with Beneficiaries

Notifying Beneficiaries

- Regulations require states to send a written consumer notice when a beneficiary reaches the cost-sharing cap.
  - Sending consumer notices involves coordination with MMIS and consumer notice system.
  - Electronic notice is sufficient only when a beneficiary indicates at application that an electronic notice is elected. State may send an email informing the individual that an E-notice has been posted to the account.
- For example, Georgia sends a notice to beneficiaries:
  - Upon eligibility determination informing the individual of his or her aggregate cap.
  - When the individual reaches his or her household cap.
- Additionally, states may offer multiple ways to access information in real time on incurred cost-sharing:
    - Online portal
    - Telephone helpline
    - Phone app
    - Provider at point-of-service

Reimbursing Beneficiaries

Reimbursement Procedures

- Enrollees may exceed their 5% cap for a few reasons:
  - Lags in provider billing
  - State tracks cost-sharing retrospectively (and not in real time)
  - If a state has authority not to track because state has demonstrated unlikelihood (but not impossibility) of beneficiary hitting the cap
- States may use one of two reimbursement approaches:
  - State reimburses the provider; provider reimburses beneficiary.

    (West Virginia, Michigan for FFS population*)*
    - State to inform beneficiary to expect reimbursement.
    - State can claim regular FFP for the cost sharing paid to the provider.
  - State reimburses the beneficiary.
- As part of state tracking obligations, beneficiaries must be informed of the process for seeking reimbursement from the state or provider.

Discussion

Appendix: Federal Cost Sharing and Premium Requirements

Overview of Federal Cost Sharing Rules

States may impose cost sharing (e.g., copayments, coinsurance and deductibles) on most Medicaid covered services

Out of pocket costs may be imposed on:

- Outpatient services
- Inpatient services
- Non-emergency use of the emergency room (ER)
- Prescription drugs

Cost sharing may be imposed on the following individuals:

- Single adults
- Parents
- Aged, Blind and Disabled (with exceptions)

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Maximum Allowable Medicaid Cost Sharing

- Any cost sharing in the state plan applies to all eligibility categories (unless exempt), with the exception of certain targeted cost sharing
- Cost sharing is subject to a 5% aggregate cap

Maximum Allowable Medicaid Cost Sharing Varies By Income

	< 100% FPL	100% - 150% FPL	>150% FPL
Outpatient Services	$4	10% of the cost state pays	20% of the cost state pays
Non-emergency Emergency Room	$8	$8	No limit [2]
Prescription drugs [1]	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: $8	Preferred: $4 Non-Preferred: 20% of cost stay pays
Inpatient Services	$75 per stay	10% of the total cost state pays for the entire stay	20% of the total cost state pays for the entire stay

(1) If non-preferred drugs are medically necessary, preferred drug cost sharing applies.
(2) Subject to 5% aggregate cap.

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Consequences for Failure to Pay Cost Sharing

Income Below 100% FPL

- Providers may not refuse to provide a service to beneficiaries on the sole basis that a beneficiary cannot pay required cost sharing

Income Above 100% FPL

- States may permit providers to refuse to treat beneficiaries for failure to pay cost sharing, unless the beneficiary is in an exempt group

SSA § 1916(e); 42 CFR § 447.52(e)

Populations Exempt From Cost Sharing and Premiums

Mandatory Exempt Populations:

- Children ages 18 and under (with limited exceptions)
- Pregnant women (states may require pregnant women above 150% FPL to pay premiums and may require cost sharing for services identified in the state plan as not pregnancy related)
- Individuals living in an institution who are required to contribute nearly all of their income toward the costs of their care
- Individuals receiving hospice care
- American Indians/ Alaska Natives who have ever received service from an Indian health care provider (those eligible to receive services from an Indian health care provider, but have never received such services, are exempt from premiums only)
- Women enrolled under the Breast and Cervical Cancer Treatment Program

Optional Exempt Populations:

- Individuals ages 19-21
- Individuals who receive home and community-based services and pay for the cost of their care

Exempt populations may still be required to pay cost sharing for non-preferred drugs or for non-emergency use of the ER.

SSA § § 1916(a),(b), 1916A(b)(3); 42 CFR § § 447.53(d), 447.54(c), 447.56(a)(1)

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Services Exempt From Cost Sharing

Emergency services

Family planning services

Preventive services

Pregnancy-related services

Services resulting from potentially preventable events (provider preventable services)

SSA § § 1916(a),(b), 1916A(b)(3)(B); 42 CFR § 447.56(a)(2)

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Cost Sharing for Non-Emergency Use of the ER

Non-Emergency Use of the ER:

≤ 150% FPL	>150% FPL
$8	No limit (but subject to 5% cap)

States may require exempt populations to pay cost sharing for non-emergency services.

Cost Sharing May Only be Imposed if Hospital, Prior to Providing Care:

1. Provides a screening at the ER as required by EMTALA
2. Informs the beneficiary of the amount of the cost sharing obligation for the non-emergency service
3. Provides the beneficiary with the name and location of an available non-emergency services provider
4. Determines that alternative provider can provide services in timely manner with lesser or no cost sharing
5. Provides a referral to coordinate treatment by the alternative provider

States may not require cost sharing for emergency care

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SSA §§ 1916(a)(3), (b)(3), 1916A(e); 42 CFR § 447.54

Cost Sharing for Non-Emergency Use of the ER (Cont'd)

CMS Considerations When Evaluating Non-Emergency Use Cost Sharing May Include:

- The state's definition of non-emergency services
- Whether there are guidelines to help ER staff distinguish between emergency and non-emergency care
- Who in the hospital discusses with the patient the cost sharing consequence of obtaining non-emergency care in the hospital
- Whether alternate sources of care are available in the geographic area with after hours and next day availability
- Whether individuals have appeal rights if they disagree with the state's determination that it was non-emergency care
- The estimated savings from implementing this type of cost sharing
- The extent to which stakeholder input was obtained

American Indians/ Alaska Natives (AI/AN) Rules

AI/AN are exempt from cost sharing:

- AI/AN who are eligible for and have ever received services from an Indian health care provider are exempt from cost sharing
- AI/AN who are eligible for services from an Indian health care provider are exempt from premiums

Exemption Process for AI/ANs Who Receive Services from an Indian Health Care Provider:

- Accept self-attestation
- Run periodic claims reviews
- Obtain an IHS "Active or Previous User Letter" or other Indian health care provider document
- Flag exempt recipients through Eligibility and Enrollment and MMIS systems

Process applies to all states and contract providers:

- All states required to implement process even if they do not have a federally recognized tribe (to accommodate AI/ANs who moved into state and are eligible for exemption)
- States also required to implement exemptions for services provided through a contract health services provider (even if not an Indian health care provider)