Table of Contents

State/Territory Name: IA

State Plan Amendment (SPA) #: 16- 002

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

August 29, 2016

Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut Street, 5th Floor
Des Moines, IA 50319-0114

Dear Mr. Palmer:

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #16-002, which proposes to implement premiums and cost sharing in accordance with 42 CFR §447.52 through 447.57 to include cost-sharing for non-emergency services provided in a hospital emergency department and cost sharing for drugs, exclusion for individuals below 50% of the federal poverty level, limitations for American Indians and Alaskan Natives (AI/AN), and cost sharing incurred by an individual will not exceed an aggregate limit of 5 percent of the family's income, effective April 1, 2016.

Based upon the information received, we are now ready to approve SPA #16-002 as of August 29, 2016, with an effective date of April 1, 2016, as requested by the state.

Enclosed is a copy of the CMS-179 form, as well as, the approved pages for incorporation into the Iowa State Plan. If you have any questions regarding this amendment, please contact Sandra Levels at (816) 426-5925 or Sandra.Levels@cms.hhs.gov.

Sincerely, 8/29/2016

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Signed by: James G. Scott -A

Enclosure

cc:
Mikki Stier, IME
Jennifer Steenblock, IME
Sandra Levels, CMS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 16 — 0 0 2

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

42 CFR 447.50, et.seq.

7. FEDERAL BUDGET IMPACT
a. FFY 2016 $ (41,224)
b. FFY 2017 $ (82,242)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

G1
G2a
G2b
G2c
G3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

New Pages

10. SUBJECT OF AMENDMENT

Updates cost-sharing requirements, relative to current Federal regs addressing same, including, but not limited to updated provisions for copays for non-emergent use of hospital ERs, exclusions for members below 50% FPL, exclusions/limitations for AI/AN.

11. GOVERNOR'S REVIEW *(Check One)*

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 3/30/2016

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 30, 2016

18. DATE APPROVED: August 29, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2016

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Division of Medicaid and Children's Health Operations

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 0938-1148

Transmittal Number: IA - 16 - 0002

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-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

☒ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

☒ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☒ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☒ Other process

Description:

MCOs are contractually required to make this information available to providers for their members. DHS reviews and approves the MCO's methodology.

☒ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

- [x] Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;
- [x] Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;
- [x] Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
- [x] Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- [x] Provide a referral to coordinate scheduling for treatment by the alternative provider.

- [✓] The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

"Non-emergency care" would be defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. Hospital ER staff will make this determination.

Cost Sharing for Drugs

The state charges cost sharing for drugs. Yes

The state has established differential cost sharing for preferred and non-preferred drugs. Yes

- [x] The state identifies which drugs are considered to be non-preferred.
- [✓] The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

Beneficiary and Public Notice Requirements

- [✓] Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

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.20140415

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 0938-1148

Transmittal Number: IA - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals — G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	
+			$	Other		X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Generic & preferred brand name drugs — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Prescription		X
+	50% FPL	No upper limit	1.00	$	Prescription	Copayment charged for each covered drug dispensed. The cost to the State is determined without regard to federal financial participation in the Medicaid program or any rebates received. Any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the Department pursuant to Iowa Code Section 249A.20A shall be treated as a preferred brand-name drug.	X

Service or Item: Non-preferred brand-name drugs for which the cost to the State is $25.01 to $50 — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Prescription		X

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	50% FPL	No upper limit	2.00	$	Prescription	Copayment charged for each covered drug dispensed. The cost to the State is determined without regard to federal financial participation in the Medicaid program or any rebates received. Any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the Department pursuant to Iowa Code Section 249A.20A shall be treated as a preferred brand-name drug.	X

Service or Item: Non-preferred brand-name drugs for which the cost to the state is $50.01 or more — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Prescription		X
+	50% FPL	No upper limit	3.00	$	Prescription	Copayment charged for each covered drug dispensed. The cost to the State is determined without regard to federal financial participation in the Medicaid program or any rebates received. Any brand-name drug not subject to prior approval based on non-preferred status on the preferred drug list published by the Department pursuant to Iowa Code Section 249A.20A shall be treated as a preferred brand-name drug.	X

Service or Item: Chiropractor services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	1.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Physical therapy — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	1.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Podiatrist services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	1.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Ambulance services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	Np upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Audiologist services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Hearing aid dealer — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Medical equipment, appliances, prosthetic devices, and sickroom supplies — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Optician services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Optometrist services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Orthopedic shoes — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Psychologist services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Rehabilitation agency services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	2.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Dental services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	3.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Hearing aids — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	3.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Services rendered in a physician (MD/DO) office visit — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Day		X
+	50% FPL	No upper limit	3.00	$	Day	Copayment charged for the total services rendered on a given date.	X

Service or Item: Medicare Part B crossover claims — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Other		X
+	50% FPL	No upper limit	1.00	$	Other	Dually eligible (Medicare and Medicaid) members must make a copayment for each Medicare Part B (crossover) claim submitted to Medicaid, for services for which Medicaid otherwise collects a copayment.	X

Service or Item: Non-Emergency use of the ER — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	0% FPL	50% FPL	0.00	$	Visit		X
+	50% FPL	No upper limit	3.00	$	Visit	Copayment charged for nonemergency services when provided in a hospital emergency room.	X

Add Service or Item

Cost Sharing for Non-preferred Drugs Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals.	No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	No

PRA Disclosure Statement

V.20140415

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 0938-1148

Transmittal Number: IA - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

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.20140415

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 0938-1148

Transmittal Number: IA - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	No

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.20140415

Medicaid Premiums and Cost Sharing

State Name: Iowa

OMB Control Number: 0938-1148

Transmittal Number: IA - 16 - 0002

Expiration date: 10/31/2014

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☑ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☑ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☑ 133% FPL; and
- ☑ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☑ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☑ SSI Beneficiaries (42 CFR 435.120).
- ☑ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☑ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☑ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☑ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☑ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☑ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☑ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☑ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☑ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. **Yes**

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. **Yes**

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☒ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☒ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☒ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☒ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☒ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☒ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☒ Other procedure

Description:

If an applicant answers yes to the following question on the single streamlined application, cost-sharing is waived: "Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?"

Additional description of procedures used is provided below (optional):

☒ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

MCOs are required to develop mechanisms, subject to State review and approval, to identify individuals exempt from cost sharing.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

☒ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

☒ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

Beneficiaries are not at risk of reaching the aggregate family limit given the low amount of cost-sharing imposed and because the State does not impose cost sharing on individuals below 50% FPL. As demonstrated in data provided to CMS, 0.5% of individuals reached the 5% cap. Therefore, in accordance with 42 CFR 447.56, the State does not apply a process to track incurred cost sharing that does not rely on beneficiary documentation. Individuals receive notice of their right to appeal if they exceed the 5% cap.

For managed care enrollees, managed care organizations (MCOs) are contractually required to develop mechanisms to track cost sharing to ensure members' total cost sharing does not exceed 5% of quarterly household income. Further, they must ensure that if the 5% limit is reached, cost sharing is no longer collected until the beginning of a new quarter and the provider's reimbursement is adjusted accordingly so that co-payment amounts are no longer deducted from claims reimbursement. The State reviews and approves the MCO's methodologies for compliance.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

MCOs are contractually required to operate a grievance and appeal process. Managed care enrollees have the opportunity to appeal to their MCO and if dissatisfied with the outcome of the MCO appeal process can file an appeal with the State through the State Fair Hearing process.

Individuals enrolled in fee-for-service can file an appeal directly with the State through the State Fair Hearing process.

☒ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

For managed care enrollees, MCOs reimburse beneficiaries and adjust claims to providers in the event a family is identified as paying over the aggregate limit. The State reviews and approves the MCO's methodologies for compliance.

Under fee-for-service, beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the quarter. The Medicaid agency will review the receipts and reimburse beneficiaries for any amount above the aggregate limit.

☒ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, beneficiaries may notify the Medicaid agency of a change in their income or other circumstance that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

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