Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section l905(p)(l) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☒ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation

4.18 (b) (Continued)

42 CFR 447.51 through 447.58

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: VERMONT

Citation
42 CFR 447.51 through
447.58

4.18 (b)(3) (Continued)

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable. There is no maximum.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: __VERMONT__

Citation		
42 CFR 447.51 through 447.58	4.18 (c)	☒ Individuals are covered as medically needy under the plan.
	(1) ☐	An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.
447.51 through 447.58	(2)	No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:
		(i) Services to individuals under age 18, or under--
		☐ Age 19
		☐ Age 20
		☒ Age 21
		Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: _____VERMONT_____

Citation 4.18 (c) (3) Unless a waiver under 42 CFR 431.55(g) applies; nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☒ 21 or older

Reasonable categories of individuals who are l8 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: _____VERMONT_____

Citation

4.18 (c) (3) (Continued)

447.51 through 447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

☐ Not applicable. There is no maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

A. The following charges are imposed on the categorically needy for services:

Service	**Type of Charge**			**Amount/Basis for Determination**
	Deductible	Coinsurance	Copayment	
Pharmacy			X	$1.00 for prescription drugs costing* less than $30.00. Copayment is based on average state payment of $12.62 per claim (as of 06/12).
			X	$2.00 for prescription drugs costing* $30.00 or more but less than $50.00.
			X	$3.00 for prescription drugs costing* $50.00 or more.
Outpatient			X	$3 per day per hospital. Copayment is based on average state payment of $243.64 per outpatient claim (as of 12/11).
Dental			X	$3.00 per provider per date of service. Copayment is based on average state payment of $138.29 per claim (as of 12/11)
Durable Medical Equipment (DME)/ Medical Supplies			X	$1.00 for DME/Medical Supplies costing* less than $30.00. Copayment is based on average state payment of $16.97 per claim (as of 06/12).
			X	$2.00 for DME/Medical Supplies costing* $30.00 or more but less than $50.00.
			X	$3.00 for DME/Medical Supplies costing* $50.00 or more.

*Cost refers to the amount of reimbursement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Vermont

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53(b) are described below:

The co-payment is deducted from the Medicaid payment unless the provider indicates an excluded category as contained on the claim form.

Vermont implements and enforces the federally required exclusions from co-payment by programming edits into the claims processing system which checks each claim for entries in date of birth, address, diagnosis, procedure code, emergency, and family planning indicator fields. Claims lacking information in any of these fields are denied. Correctly completed claims are edited against the copayment exclusion information in the system to determine whether or not a copayment is required.

American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State are exempt from co-payments.

Vermont will accept documentation from Indian Health Providers and Urban Indian Organizations, such as the IHS active or previous user letter, which indicates that the individual has received a service from an I/T/U, and the State will then provide an edit in the system exempting the individual from cost sharing.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

The Department of Vermont Health Access's (DVHA's) fiscal agent performs a calculation and produces a report, within thirty (30) days after the end of each quarter, indicating if any Medicaid beneficiaries have exceeded the 5% of the family's gross income for cost sharing. 5% of the family's gross income will not be exceeded in any quarter. The amount above the 5% cap is refunded to the beneficiary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 1916(a)(2) and (j) of the Social Security Act and 42 CFR 447.53 (b) are described below:

The co-payment is deducted from the Medicaid payment unless the provider indicates an excluded category as contained in 42 CFR 447.53(b) on the claim form.

Vermont implements and enforces the federally required exclusions from co-payment by programming edits into the claims processing system which checks each claim for entries in date of birth, address, diagnosis, procedure code, emergency, and family planning indicator fields. Claims lacking information in any of these fields are denied. Correctly completed claims are edited against the copayment exclusion information in the system to determine whether or not a copayment is required.

American Indians/Alaska Natives (AI/AN) who currently or have previously received services by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or through a referral under contract health services in any State are exempt from co-payments.

Vermont will accept documentation from Indian Health Providers and Urban Indian Organizations, such as the IHS active or previous user letter, which indicates that the individual has received a service from an I/T/U, and the State will then provide an edit in the system exempting the individual from cost sharing.

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

The Department of Vermont Health Access's (DVHA's) fiscal agent performs a calculation and produces a report, within thirty (30) days after the end of each quarter, indicating if any Medicaid beneficiaries have exceeded the 5% of the family's gross income for cost sharing. 5% of the family's gross income will not be exceeded in any quarter. The amount above the 5% cap is refunded to the beneficiary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _____Vermont_____

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Pharmacy			X	$1.00 for prescription drugs costing* less than $30.00. Copayment is based on average state payment of $12.62 per claim (as of 06/12).
			X	$2 00 for prescription drugs costing* $30.00 or more but less than $50.00.
			X	$3.00 for prescription drugs costing* $50.00 or more.
Outpatient			X	$3 per day per hospital. Copayment is based on average state payment of $243.64 per outpatient claim (as of 12/11).
Dental			X	$3.00 per provider per date of service. Copayment is based on average state payment of $138.29 per claim (as of 12/11)
Durable Medical Equipment (DME)/Medical Supplies			X	$1.00 for DME/Medical Supplies costing* less than $30.00. Copayment is based on average state payment of $16.97 per claim (as of 06/12).
			X	$2.00 for DME/Medical Supplies costing* $30.00 or more but less than $50.00.
			X	$3.00 for DME/Medical Supplies costing* $50.00 or more.
				*Cost refers to the amount of reimbursement.