



# Overview of Medicaid Cost Sharing and Premium Requirements

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# Overview

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- **Medicaid Cost Sharing Rules**
- **Medicaid Premium Rules**
- **Aggregate Cost Sharing and Premium Limits**
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- **Public Notice and Consumer Communication Rules**
- **Waiver Options for Cost Sharing and Premiums**
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# Medicaid Cost Sharing Rules

# Overview of Federal Cost Sharing Rules

States may impose cost sharing (e.g., co-payments, 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)

# 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
- Targeted cost-sharing may only be applied to individuals with incomes above 100% FPL

## Maximum Allowable Medicaid Cost Sharing Varies By income

	< 100% FPL	100% - 150% FPL	>150% FPL
<b>Outpatient Services</b>	\$4	10% of the cost state pays	20% of the cost state pays
<b>Non-emergency ER</b>	\$8	\$8	No limit <sup>2</sup>
<b>Prescription drugs <sup>1</sup></b>	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost stay pays
<b>Inpatient Services</b>	\$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.

# Cost Sharing Limits for Prescription Drugs

## Preferred Drugs:

All income levels

\$4

## Non-Preferred Drugs:

≤ 150% FPL

\$8

> 150% FPL

20% of the amount the agency pays for the drug

States may require exempt populations to pay cost sharing for non-preferred drugs.



# Cost Sharing Limits for Prescription Drugs (Cont'd)

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## Preferred Drugs vs. Non-Preferred Drugs:

- Drugs are considered preferred if the state does not differentiate between the two classes of drugs
- Preferred drug limits apply to non-preferred drugs if prescribing provider determines that therapeutically equivalent preferred drug will be less effective or will have adverse effects.
  - In this case, states must ensure that beneficiaries are only charged the preferred drug amount
- If a state seeks to impose differential cost sharing for brand generic v. brand name drugs, it must be implemented within the framework of preferred and non-preferred drugs

## Alternatives to Cost Sharing:

- Prior authorization
- Automatic substitution of generics for brand name drugs
- Step therapy (e.g., first prescribe most cost-effective drug then progress to other more costly drugs)



# 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**

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

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## 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



# Authorized Variations in Cost Sharing Amounts under SPA

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## States May Vary Cost Sharing Based On:

**Provider Type:** State may have lower cost sharing levels for primary care to encourage utilization

**Income Level:** So long as cost sharing not higher for those with lower incomes

**Eligibility Group:** If the variation occurs for those above 100% FPL

## States May Not Vary Cost Sharing Based On:

**Eligibility Group:** If differential cost sharing is imposed for those below 100% FPL

**Delivery System:** States may not vary cost sharing based on whether an individual enrolls in managed care or fee-for-service

- MCOs must abide by premium and cost sharing limits, but MCOs may charge lower cost sharing
- Payments to MCOs must reflect the state's cost sharing rules, even if the MCO does not charge cost sharing

# Penalties 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

# Populations Exempt from Cost Sharing and Premiums

## Mandatory Exempt Populations:

- Children 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.*

# 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)

# Services Exempt from Cost Sharing



Emergency services



Family planning services



Preventive services provided to children



Pregnancy-related services



Services resulting from potentially preventable events  
(provider preventable services)

# Requirements of a Cost Sharing State Plan Amendment (SPA)

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- Identification of populations to whom state will apply cost sharing
- Identification of what services are subject to cost sharing and the amount of cost sharing
- Affirmation that cost sharing plan properly excludes all exempt populations and services
- Identification of the amount of the state's aggregate limit, if less than 5%
- Explanation of tracking and monitoring processes
- Assurance that appropriate and adequate advanced public notice was provided

The image shows a screenshot of the CMS Medicaid Premiums and Cost Sharing form. The form is titled "CMS Medicaid Premiums and Cost Sharing" and includes fields for State Name, OMB Control Number (0938-1148), Transmittal Number, and Expiration date (10/31/2014). The main section is "Cost Sharing Requirements" with a "GI" label. It contains a table with columns for "Code" and "Description". The table lists "0154" and "0155A" with descriptions related to CFR 447.50 through 447.57. Below the table is a section for "The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid" with a dropdown menu. A "PRA Disclosure Statement" is also present, providing information about the Paperwork Reduction Act of 1995 and the OMB control number. The form is dated 10/30/14.

# Considerations in Implementing Cost Sharing

## Incentivizing Care:

- Cost sharing may be used to incentivize utilization of certain services (e.g., no cost sharing for preventive care) or to discourage utilization of service (e.g., cost sharing for non-emergency use of ER)

## Accessing Care:

- Cost sharing can be a barrier to care, especially for low-income populations
- For individuals with extremely low income levels (e.g., 0-20% of the FPL) even nominal cost sharing can be extremely challenging to pay

## Tracking and Monitoring Expenses:

- State must establish administrative structure for tracking, monitoring and enforcing 5% cap

# Medicaid Premium Rules

## Income Below 150% FPL: Limitations on Premiums

- For most eligibility groups, state may not impose premiums under the state plan (waiver is required)
- Through a state plan amendment, state may impose premiums on the medically needy and the working disabled on a sliding scale based on income

## Income Below 150% FPL: Penalties for Failure to Pay Premiums

- If state does require the working disabled to pay premiums, the state may terminate for failure to pay
- The state may not terminate medically needy beneficiaries for failure to pay

# Federal Premium Requirements (Cont'd)

## Income Above 150% FPL: Limitations on Premiums

- State may impose premiums through a State Plan Amendment
- Premiums are included in 5% cap

## Income Above 150% FPL: Penalties for Failure to Pay Premiums

- States may terminate an individual from Medicaid if the individual fails to pay premiums for 60 days or more
- The state may not terminate medically needy beneficiaries for failure to pay

# Aggregate Cost Sharing and Premium Limits

## Premiums and Cost Sharing

- Medicaid premiums and cost sharing are capped at 5% of family income
- If state adopts premium and cost sharing rules that “could place beneficiaries at risk of reaching the aggregate family limit,” state must track beneficiaries’ premiums and cost sharing



# Tracking Premiums and Cost Sharing Against 5% Cap

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## Tracking System



- Tracking system must be “an effective mechanism that does not rely on beneficiary documentation”
- Tracking system must include a mechanism for notifying beneficiaries and providers when the aggregate limit has been reached
- States must track amount of cost sharing and premiums incurred, not just amount paid
- State must determine whether each beneficiary’s cost sharing and premiums exceed the aggregate limit on either a monthly or quarterly basis, at the state’s option
- States are encouraged to track costs through Medicaid Management Information System

# Summary of Cost Sharing and Premium Limits

# Summary of Cost Sharing and Premium Limits by Income

## Maximum Allowable Medicaid Premiums and Aggregate Cost-Sharing:

	< 100% FPL	100% - 150% FPL	>150% FPL
Premiums	Not allowed	Not allowed	Permitted, subject to aggregate cap
Aggregate cost sharing cap	5% household income	5% household income	5% household income

## Maximum Service-Related Co-pays/Co-Insurance:

Outpatient Services	\$4	10% of the cost state pays	20% of the cost state pays
Non-emergency ER	\$8	\$8	No limit <sup>2</sup>
Prescription drugs <sup>1</sup>	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

*This chart is subject to the following assumptions: 1) The services are provided to non-exempt populations. 2) The services are not exempt from cost sharing. 3) No state waiver for cost -sharing or premiums is applicable.*

*Dollar amounts are to be changed every year to account for inflation.*

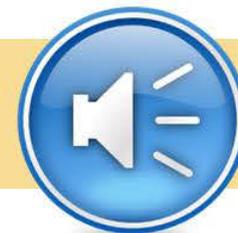
*(1) If non-preferred drugs are medically necessary, preferred drug cost sharing applies.*

*(2) Subject to 5% aggregate cap and may not exceed the cost of the service*

# Public Notice and Consumer Communication

# Public Notice and Consumer Communication Rules

**States must provide the following information to beneficiaries at time of enrollment and at time of any changes to cost sharing and premiums:**



- Groups who are subject to premiums and cost sharing
- Amounts of premiums and cost sharing
- Mechanisms for making payment for premiums and cost sharing
- Consequence of not paying premiums or cost sharing
- List of hospitals, if any, that charge cost sharing for non-emergency use of the emergency department
- List of preferred drugs subject to lower cost sharing

***States must also make this information publically available***



**States must provide public notice of premiums and cost sharing state plan amendments**

- Appropriate vehicles for notice include an agency website, newspapers with wide circulation, and formal notice and comment

# Waiver Options for Cost Sharing and Premiums

# Waiver of Cost Sharing Limits

Cost sharing waivers may be imposed under demonstration projects. In order for CMS to approve the waiver, it must find that the cost sharing waiver:

- ✓ Tests a unique and previously untested use of copayments
- ✓ Provides benefits to Medicaid recipients which can be reasonably expected to be equivalent to the risks to the recipients
- ✓ Is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner
- ✓ Is limited to a two-year period or less
- ✓ Is either voluntary or makes provision for assumption of liability for injury to the health of beneficiaries that results from involuntary participation

# Premium Waivers: Limitations and Penalties



## IOWA:

- Premiums imposed on those with incomes above 50% FPL
- Premiums up to \$5/month for those between 50-100% FPL and \$10/month for those between 100-138% FPL
- Beneficiaries with incomes above 100% FPL may lose coverage if they do not pay premiums for 90 days and do not request a hardship waiver



## MICHIGAN:

- Premiums imposed on those with incomes above 100% FPL
- Premiums are up to 2% of income
- Beneficiaries will not lose their coverage if they fail to pay premiums
- Premiums may be reduced for meeting Healthy Behaviors standards



## PENNSYLVANIA:

- Premiums imposed on those with incomes above 100% FPL
- Premiums are set at 2% of income
- Beneficiaries who fail to pay their monthly premiums for three consecutive months will be dis-enrolled from coverage, but may re-apply without a waiting period or repayment of back premiums
- Premiums may be reduced for meeting Healthy Behavior standards

# State Experiences

# Georgia's PeachCare (CHIP) Implementation Experience



Georgia

## SYSTEMS

- Co-pays are tracked through: (1) fee for service claims; and (2) managed care plan claims:
  - Tracking fee for service co-payments is straightforward
  - Three CHIP managed care plans are required to feed encounter information directly into MMIS.
- Cost-sharing is tracked on a monthly basis
- Once a member reaches the cap, a notification report is sent to the eligibility system to stop the premium and co-payment

## CONSUMER NOTICES:

- Upon initial eligibility determination, family is sent a notice informing them of their annual cost-sharing limit based on their income
- Once a family hits the 5% cap, they are sent a notice that they are not responsible to pay premiums or cost-sharing for the remainder of their coverage year

## PROVIDER COMMUNICATION:

- Providers verify at point of service whether patient has a co-payment
- PeachCare maintains a web-based system and call center to which all qualified Medicaid providers (including pharmacists) have access

## CHALLENGES

- Tracking systems took a year and a half to build
- Systems challenge uploading health plan file transfer to MMIS in a consistent format
- Very few families hit 5% cap

# Kentucky's Medicaid Implementation Experience



## SYSTEMS

- Co-pays are tracked through: (1) fee for service claims; and (2) managed care plan claims:
  - MMIS track's fee for service claims
  - Managed care plans (MMC) are responsible for tracking managed care beneficiaries' co-payments (90% of total enrollment)
- Cost-sharing is tracked on a quarterly basis
- Once a member reaches the cap, the copayment indicator is turned off in the systems and providers can see whether a co-payment should be applied or not.

## PROVIDER COMMUNICATION:

- Providers verify at point of service whether patient has a co-payment
  - Managed care plans maintain a web-based system to which all qualified Medicaid providers (including pharmacists) have access;
  - State maintains web-based system for fee for service beneficiaries.

## CHALLENGES

- Because of lag of claims data 5% cap is difficult to track on a real time basis
- Less than 1% of Medicaid beneficiaries ever reach 5% cap

Questions?