Cost-Sharing—Limitations

One of the areas in which states seem particularly open to saving Medicaid expenditures is that of cost-sharing. In 2004, we can anticipate that new or increased co-payments, deductibles, and premiums will be instituted by a number of states. In establishing cost-sharing requirements, however, a state is bound by very specific federal statutory and regulatory limits.

a. With limited exceptions, a state may not impose any “enrollment fee, premium or similar charge” on categorically needy recipients or Qualified Medicare Beneficiaries (QMB). 42 CFR 447.51 and 447.53 Such charges may be imposed on the medically needy, but are subject to certain limitations including maximum monthly charges related to gross family income specifically itemized in the federal regulation—for example, the maximum monthly charge for a family of 3 or 4 with gross family income of $701-$750 is $10. 42 CFR 447.52(b).

b. A state can impose only a “nominal” deductible, copayment, or similar charge on categorically or medically needy recipients. 42 CFR 447.53(a) However, certain groups or services must be excluded from these charges, including services to children under age 18, services furnished to pregnant women if related to pregnancy or conditions that can complicate pregnancy, services to institutionalized persons who are contributing most of their income to the cost of their care, emergency services, family planning services and hospice services. 42 CFR 447.53(b) Again, federal regulations (42 CFR 447.54) establish specific numerical limits in applying the term “nominal,” for example:

--for non-institutionalized services, a deductible could not exceed $2 per month per family for each period of eligibility. Thus, if a family is certified for Medicaid for a three-month period, its deductible for that period could not exceed $6.
--coinsurance cannot exceed 5% of the payment that the state agency makes for the service;
--co-payments are limited to specific limits set in the federal regulation—for example, if a state payment for a service is between $25.01-$50, the maximum co-payment chargeable to the patient is $2.

In short, states may apply various forms of cost-sharing, but unless they have received from CMS a Section 1115 waiver that allows them to waive the above limitations, they must adhere to them. In addition, there is some question as to whether CMS has legal authority to waive a number of the federal cost sharing provisions even under Section
1115. PCAs should look carefully at state cost-sharing proposal since they obviously can result in direct or indirect loss of funds to the center, and might consider working with allies who also would be impacted by such increases—such other providers, advocacy groups and legal aid programs that represent Medicaid recipients.
to implement an automated claims processing and information retrieval system.

The agency's request for a waiver must contain a written statement of the reasons why the waiver is necessary and the plan for meeting the requirements of this section.

(3) The Administrator will review each case and, if he approves the waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) Prepayment and postpayment claims review.

(1) For all claims, the agency must conduct prepayment claims review consisting of—

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

(ii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iii) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan.

(v) Checks for third party liability within the requirements of § 438.157 of this chapter.

(2) The agency must conduct post-payment claims review that meets the requirements of parts 456 and 456 of this chapter, dealing with fraud and utilization control.

(g) Reports. The agency must provide any reports and information on compliance with this section that the Administrator may require.

§ 447.46 Timely claims payment by MCOs.

Compliance date of section is Aug. 13, 2003, see 67 FR 40989 and 42609.

(a) Basis and scope. This section implements section 6(f) of the Act by specifying the rules and exceptions for prompt payment of claims by MCOs.

(b) Definitions. "Claim" and "clean claim" have the meaning given those terms in § 447.45.

(c) Contract requirements. A contract with an MCO must provide that the MCO must—

(1) Maintain an alternative payment schedule that meets the requirements of §§ 447.45(d)(2) and (d)(3), and abide by the specifications of §§ 447.45(d)(5) and (d)(6).

(2) Establish an alternative payment schedule for the plan.

(3) Alternative schedule. Any alternative schedule must be stipulated in the contract.

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require recipients to share some of the costs of Medicaid by charging them such payments as enrollment fees, premium, deductibles, coinsurance, co-payments, or similar cost-sharing charges. For States that impose cost sharing payments, §§ 447.51—447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

§ 447.51 Requirements and options.

(a) The plan must provide that the Medicaid agency does not impose any enrollment fee, premium, or similar charge upon categorically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(b) The plan may impose an enrollment fee, premium, or similar charge on medically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(c) For each charge imposed under paragraph (b) of this section, the plan must specify—

(1) The amount of the charge;

(2) The period of liability for the charge; and

(3) The consequences for an individual who does not pay.

(d) The plan must provide that any charge imposed under paragraph (b) of this section is related to total gross family income and is imposed on each—

(1) One- or two-person family with monthly gross income of $150 or less;

(2) Three- or four-person family with monthly gross income of $300 or less; and

(3) Five- or more-person family with monthly gross income of $350 or less.

(b) Maximum charge. Any charge related to gross family income that is above the minimum listed in paragraph (a) may not exceed the standards shown in the following table:

<table>
<thead>
<tr>
<th>Gross family income (per month)</th>
<th>1 or 2</th>
<th>3 or 4</th>
<th>5 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150 or less</td>
<td>$1</td>
<td>$1</td>
<td>$1</td>
</tr>
<tr>
<td>$151 to $200</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>$201 to $250</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>$251 to $300</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>$301 to $350</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>$351 to $400</td>
<td>6</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>$401 to $450</td>
<td>7</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>$451 to $500</td>
<td>8</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>$501 to $550</td>
<td>9</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>$551 to $600</td>
<td>10</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>$601 to $650</td>
<td>11</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>$651 to $700</td>
<td>12</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>$701 to $750</td>
<td>13</td>
<td>10</td>
<td>9</td>
</tr>
<tr>
<td>$751 to $800</td>
<td>14</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>$801 to $850</td>
<td>15</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>$851 to $900</td>
<td>16</td>
<td>13</td>
<td>12</td>
</tr>
</tbody>
</table>
(c) Income-related charges. The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.


§ 447.55 Applicability; specification; multiple charges.

(a) Basic requirements. Except as specified in paragraph (b) of this section, the plan may impose a nominal deductible, coinsurance, copayment, or similar charge upon categorically and medically needy individuals for any service under the plan.

Compliance date of subsection (b) intro. par. is Aug. 13, 2005, see 67 FR 40989 and 42809.

(b) Exclusions from cost sharing. The plan may not provide for impositions of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals for the following:

(1) Children. Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) Pregnant women. Services furnished to pregnant women if such services related to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine postpartum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate 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. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) Institutionalized individuals. Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to §§ 435.725, 435.733, 435.832, or 436.832), as a condition of receiving services in the institution, to spend all or a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) Emergency services. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(5) Family planning. Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(c) Prohibition against multiple charges. For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.

(d) State plan specifications. For each charge imposed under this section, the plan must specify—

(1) The service for which the charge is made;

(2) The amount of the charge;

(3) The basis for determining the charge;

(4) The basis for determining whether an individual is unable to pay the charge and the means by which such individual will be identified to providers; and

(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual's inability to pay the cost sharing.


§ 447.54 Maximum allowable charges.

(a) Non-institutional services. Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

(1) Any deductible it imposes does not exceed $2.00 per month for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $6.00;

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the service; and

(3) Any co-payments it imposes do not exceed the amounts shown in the following table:

<table>
<thead>
<tr>
<th>States payment for the service</th>
<th>Maximum co-pay-</th>
<th>to recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 or less</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>$10.01 to $25</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>$26.01 to $50</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

(b) Waiver of the requirement that cost sharing amounts be nominal. Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(c) Institutional services. For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) Cumulative maximum. The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

[45 FR 5736, Jan. 8, 1983]