G3 - Cost Sharing Limitations

Statute: 1916, 1916A
Regulation: 42 CFR 447.56

INTRODUCTION

State plan page (fillable PDF) G3 includes information regarding mandatory exemptions from cost sharing and other cost sharing limitations. This state plan page is also used for states to indicate additional optional exemptions, as well as, the procedures used to implement and enforce cost sharing exemptions and to meet the tracking requirement.

State plan page G3 must be submitted by states implementing cost sharing for the first time or for the initial cost sharing state plan amendment submission in MMDL for existing cost sharing in the state plan.

For subsequent state plan amendment submissions, state plan page G3 need only be submitted when changes are being proposed to the general provisions contained on page G3.

BACKGROUND

For background information related to the cost sharing state plan pages, including state plan page G3, please see separate document, titled "Background - Medicaid Cost Sharing".

TECHNICAL GUIDANCE

PREREQUISITES:

If the state is proposing to establish new cost sharing or modify existing cost sharing in the state plan, and has submitted G2a, G2b, or G2c, it must submit page G3. Once G3 is approved, it does not need to be submitted with future state plan amendments, unless the state wants to change any of its policies included in G3 related to any new SPA that is submitted.

State plan page G3 begins with the state providing assurance that 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.

The state provides this affirmative assurance by checking the box next to the assurance statement.

Review Criteria

The state must check the assurance box or this state plan page cannot be approved.

The remainder of this state plan page is divided into the following sections:

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- Groups of Individuals - Mandatory Exemptions
- Groups of Individuals - Optional Exemptions
- Services - Mandatory Exemptions
- Enforceability of Exemptions
- Payments to Providers
- Payments to Managed Care Organizations
- Aggregate Limits

For each Yes or No question, if Yes or No is not selected by the state, this state plan page cannot be approved.

Groups of Individuals - Mandatory Exemptions

This section consists of a list of groups of individuals who are exempt from cost sharing. These are all pre-checked as they are mandatory exemptions for all states imposing cost sharing.

Groups of Individuals - Optional Exemptions

The state must first select ***Yes*** or **No** as to whether the state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over.

If ***Yes***, the state then selects one of the four options listed. If the state checks, "Other reasonable category", they must describe the category of individuals in the text box.

Review Criteria

If one of the options is not selected, this state plan page cannot be approved. If "other reasonable category" was selected, a description must be entered or this state plan page cannot be approved. The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

The state then selects ***Yes*** or **No** as to whether 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.

Review Criteria

If Yes or No is not selected, this state plan page cannot be approved.

Services - Mandatory Exemptions

This section consists of a list of groups of services which are exempt from cost sharing. These are all pre-checked as they are mandatory exemptions for all states imposing cost sharing.

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Enforceability of Exemptions

In this section states provide information about their procedures for implementing and enforcing exemptions from cost sharing for American Indians/Alaskan Natives (AI/AN) and all other individuals exempt from cost sharing.

American Indians/Alaskan Natives (AI/AN)

First, the state provides information about procedures used to identify American Indians/Alaskan Natives (AI/AN) 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 in accordance with 42 CFR 447.56(a)(1)(x). The state must select one or more of the five options listed. If the state selects "Other procedure," it must enter a description(s) of the other procedure(s).

Review Criteria

If the state did not select at least one of the options listed, this state plan page cannot be approved. If "other procedure" was selected, at a minimum, one other procedure description must be entered or this state plan page cannot be approved. The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Next, at the state's option the state may provide additional description for any of the enforcement procedures selected or entered by the state.

All Other Individuals Exempt from Cost Sharing

First, the state provides information about procedures used to identify all other individuals exempt from cost sharing. The state must select one or more of the five options listed. If the state selects "Other procedure", it must enter a description of the other procedure(s).

Review Criteria

If the state did not select at least one of the options listed, this state plan page cannot be approved. If "other procedure" was selected, at a minimum, one other procedure description must be entered or this state plan page cannot be approved. The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements.

Next, at the state's option the state may provide additional description for any of the enforcement procedures selected or entered by the state.

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Payments to Providers

The state must provide assurance that 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).

The state provides this affirmative assurance by checking the box next to the assurance statement.

Review Criteria

The state must check the assurance box or this state plan page cannot be approved.

Payments to Managed Care Organizations

The state must select ***Yes*** or ***No*** to indicate whether or not the state contracts with one or more managed care organizations to deliver services under Medicaid.

If ***Yes***, the state must then provide assurance that it 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.

The state provides this affirmative assurance by checking the box next to the assurance statement.

Review Criteria

The state must check the assurance box or this state plan page cannot be approved.

Aggregate Limits

This section includes the following 2 subsections:

- Aggregate Limit
- Additional Aggregate Limits

Aggregate Limit

The state must first provide assurance that 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 state provides this affirmative assurance by checking the box next to the assurance statement.

Review Criteria

The state must check the assurance box or this state plan page cannot be approved.

Next the state must select the percentage of family income used for the aggregate limit from the list provided. The state selects only one of the options. If the state selects "Other," then it must enter a percentage amount. Since the maximum aggregate limit cannot exceed 5 percent of family income, the amount entered cannot be greater than 5.

Review Criteria

The state must check one of the options listed or this state plan page cannot be approved. If the state selected "Other," it must enter an amount in the percentage box or this state plan page cannot be approved. The number entered cannot be greater than 5 or this state plan page cannot be approved.

Next, the state selects either quarterly or monthly to indicate the frequency by which the state calculates family income for the purpose of the aggregate limit.

Review Criteria

The state must select either quarterly or monthly or this state plan page cannot be approved.

Next, the state must select ***Yes*** or ***No*** to indicate whether 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.

If ***No***, the state must provide an explanation of why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit.

If ***Yes***, the state is then asked to describe the tracking mechanism. The state does so by selecting one or more of the three options listed. If the state selects "Managed care organization(s) track each family's incurred cost sharing, as follows," it must then enter a description of the tracking process used by the managed care organizations. If the state selects "Other process," it must enter a description of the other tracking process used.

Next the state must describe how the state informs beneficiaries and providers of the beneficiaries' aggregate limit and notifies beneficiaries and providers when a beneficiary has

incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Next the state must select ***Yes*** or ***No*** to indicate if it 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.

If ***Yes***, the state must then describe the appeals process used.

Next, the state must 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.

Finally, the state must 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.

Review Criteria

All relevant descriptions that have to be entered under this section should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. If the state does not enter this description, this state plan page cannot be approved.

Additional Aggregate Limits

In the last section of this state plan page, the state must select ***Yes*** or ***No*** to indicate if the state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). For example, if the state places a monthly or annual limit on cost sharing charges for a particular service, they would select ***Yes*** here.

If ***Yes***, the state must then describe the additional aggregate limits used.

Review Criteria

The description should be sufficiently clear, detailed and complete to permit the reviewer to determine that the state's election meets applicable federal statutory, regulatory and policy requirements. If the state answers Yes but does not enter the description of at least one state aggregate limit, this state plan page cannot be approved.