# Background - Medicaid Cost Sharing

**Statute:** 1916, 1916A
**Regulation:** 42 CFR 447.50 - 447.57 (excluding 447.55)

This document provides background information for state plan pages G1 (Cost Sharing Requirements); G2a (Cost Sharing Amounts-Categorically Needy); G2b (Cost Sharing Amounts-Medically Needy); G2c (Cost Sharing Amounts-Targeting) and G3 (Cost Sharing Limitations). Corresponding technical guidance for each of these state plan pages is provided in separate documents.

## BACKGROUND

The cost sharing final rule published by CMS on July 15, 2013 (78 FR 42307), updated and simplified existing Medicaid premium and cost sharing requirements. The regulations no longer distinguish between the two statutory authorities for cost sharing (sections 1916 and 1916A of the Act) and instead simply lay out the parameters under which cost sharing is permitted.

The maximum allowable cost sharing levels were updated, including options for states to establish higher cost sharing for non-preferred drugs, and for non-emergency use of the emergency department (ED). These updated maximums apply regardless of whether the cost sharing methodology used is a deductible, copayment or coinsurance.

### Exemptions from Cost Sharing

Exemptions from cost sharing outlined in 1916 and 1916A of the Social Security Act were consolidated into one set of exemptions at 42 CFR 447.56(a). Some of the exemptions apply to specific segments of the Medicaid population and others to specific services or items.

### Comparability

To ensure comparability, states may not exempt additional individuals from cost sharing obligations that apply generally to all groups covered under the state plan. Any cost sharing included in the state plan applies equally to services or items provided under fee-for-service, managed care, or benchmark coverage. The only exception to comparability is targeted cost sharing, as allowed in 42 CFR 447.52(d).

### Targeted Cost Sharing

Consistent with 1916A, revised 42 CFR 447.52(d) clarifies that states may target cost sharing to specific individuals with family incomes above 100% of the FPL. For non-preferred drugs and nonemergency services provided in a hospital emergency department, targeting can be applied to individuals at all income levels. Cost sharing can only be targeted by eligibility group and income levels.

# Background - Medicaid Cost Sharing

States may impose different cost sharing for different groups of individuals or target cost sharing to only certain groups. For example, a state may decide to charge cost sharing only to individuals eligible under the new adult group with income over 100% FPL, or to both the new adult group and parents/caretaker relatives over 100% FPL.

Note: An individual may be subject to both targeted cost sharing and non-targeted cost sharing if the state elects to impose both. For example, if the state imposes a $3 copay for physician services for the entire state plan population but also imposes targeted cost sharing of $2 for non-preferred drugs for just individuals in the adult group with income over 100% FPL, those adults would be subject to both the $3 physician visit copay and the $2 non-preferred drug copay and all would be counted toward the individual's aggregate family cap.

Conversely, a state wishing to impose cost sharing for services or items to the new adult group cannot target cost sharing to the entire adult group. The following three scenarios demonstrate the available options:

***Scenario 1***

The state imposes cost sharing to all non-exempt categorically needy individuals. In this scenario, the adult group at all income levels would be subject to the same cost sharing as imposed on all non-exempt categorically needy beneficiaries.

***Scenario 2***

In addition to the1916 cost sharing, the state can impose higher cost sharing for adult group beneficiaries with family incomes above 100% of the FPL. For example, the state imposes a $2 copay for an office visit on the entire state plan population, and also imposes targeted cost sharing of $5 for an office visit on individuals eligible under the adult group with family income above 100% of the FPL. In this scenario, the adult group beneficiaries with family incomes at or below100% of the FPL would be charged $2 and those with family incomes above 100% of the FPL would be charged $5. All other individuals covered under the state plan would also be charged $2 for an office visit, regardless of income level.

***Scenario 3***

The state does not want to charge cost sharing to all individuals covered under the state plan. The only option left for states wishing to impose cost sharing to adult group beneficiaries is targeted cost sharing. In this scenario adult group beneficiaries at or below 100% of the FPL cannot be charged cost sharing. The state determines at what income level, above 100% of the FPL, the cost sharing would apply for adult group beneficiaries. Let's assume that the state wants to charge $5 for office visits and chooses to target the cost sharing to individuals with family income above 100% of the FPL. In this scenario, the adult group beneficiaries

with family incomes at or below 100% of the FPL would not be charged any cost sharing and only those with family incomes above 100% of the FPL would be charged the $5.

**Outpatient Services or Items**

For outpatient services or items, one flat maximum allowable cost sharing charge of $4 replaces the previous nominal limits which were based on what the agency pays for the service. This is the maximum amount allowed for individuals with family income at or below100% of the FPL. For higher income individuals, the maximum allowable cost sharing is a percentage of the amount the agency pays for the service (10% for individuals with family income greater than 100% of the FPL up to and including 150% of the FPL and 20% for individuals with family income greater than150% of the FPL).

**Inpatient Services**

For inpatient services, a flat maximum allowable cost sharing charge of $75 per inpatient stay replaces the previous nominal amount of 50% of what the agency pays for the first day of care. This is the maximum amount allowed for individuals with family income at or below100% of the FPL. For higher income individuals, the cost sharing limit is a percentage of the amount the agency pays for the entire stay (10% for individuals with family income greater than 100% of the FPL up to and including 150% of the FPL and 20% for individuals with family income greater 150% of the FPL).

**Prescription Drugs**

States have the flexibility to apply differential cost sharing for preferred and non-preferred drugs. The maximum allowable cost sharing for preferred drugs is $4. The maximum allowable cost sharing for non- preferred drugs is $8. The $8 nominal limit for non-preferred drugs applies to non-exempt individuals with income equal to or less than 150% of the FPL. If the state chooses to charge cost sharing for non-preferred drugs to otherwise exempt individuals, the maximum allowable amount is $8 at all income levels. The cost sharing limit for non-exempt individuals with income greater than 150% of the FPL is 20% of the cost the agency pays for the non-preferred drug.

All drugs within a class will be considered to be preferred unless the state differentiates between preferred and non-preferred drugs.

**Non-Emergency Services Provided in a Hospital Emergency Department**

Cost sharing for non-emergency use of the ED for families with income equal to or less than 150% of the FPL is limited to $8. The $8 limit also applies to individuals who are otherwise exempt from cost sharing.

Other than the aggregate cap of 5% of family income, there is no specific limit on the cost sharing amount that may be imposed for non-emergency use of the ED for non-exempt beneficiaries with family income above 150% of the FPL. However, the cost sharing charge cannot be equal to or more than what the agency pays for the service.

For the state to impose cost sharing for non-emergency services provided in a hospital ED, the state must require hospitals to first conduct a clinical screen to determine whether or not an emergency medical condition exists, and if not an emergency, identify an accessible and available alternative provider with lesser cost sharing, or no cost sharing if being charged to otherwise exempt individuals, and establish a referral to coordinate scheduling.

**Income-Related Cost Sharing Charges**

Cost sharing charges may be varied based on the beneficiaries' family income. If a state establishes different cost sharing charges for individuals at different income levels, the state must ensure that the charges for lower income individuals are less than those for individuals with higher incomes and that none of the charges exceed the regulatory maximums.

**Denial of Services or Items for Nonpayment**

Except as noted below, states may not allow providers to deny services or items on account of the individual's inability to pay the cost sharing. Although services or items may not be denied, the individual receiving services or items for which there is a cost sharing requirement continues to be liable for the charge unless it is waived by the provider.

The state may permit a provider, including a pharmacy or hospital, to require an individual to pay cost sharing as a condition for receiving the item or service if:

- The individual has family income above 100 percent of the FPL;
- The individual is not part of an otherwise exempt group under 42 CFR 447.56(a); and
- For cost sharing imposed for non-emergency services furnished in an emergency department, the conditions under 42 CFR 447.54(d) have been satisfied.

**Payments to Providers**

States must reduce payments to providers 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 in 42 CFR 447.56(c).

**Aggregate Limit**

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

# Background - Medicaid Cost Sharing

States are required to inform beneficiaries and providers of the amount of the beneficiaries' aggregate family limit, and when the beneficiary has reached the limit and is no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

**Public Notice**

States must make available a public schedule describing current premiums and cost sharing requirements. The public schedule must be provided in a manner that is accessible to all impacted parties (applicants, beneficiaries and providers), as well as the general public.

Advance public notice and input is required prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies. At a minimum, the advance notice must include the amounts of cost sharing, who is subject to the charges, and consequences for non-payment.