# MISSOURI SENATE

## DIVISION OF RESEARCH

State Capitol, Room B-9, Jefferson City, MO 65101
TEL. (573) 522-7910 FAX (573) 751-4778


H:\ADRIANE\A 2013 MEDICAID INTERIM COMMITTEE\CMS Final Rules copays

TO: Senator Romine, Chair
Committee Members
Senate Interim Committee on Medicaid Transformation and Reform

FROM: Adriane Crouse, Assistant Director

DATE: October 2, 2013

RE: CMS Final Rule on Medicaid Cost Sharing

Your office has requested information regarding permissible requirements with respect to cost sharing from Medicaid participants. Recently on July 15, 2013, the Centers for Medicare and Medicaid Services (CMS) published a final rule in the Federal Register updating many of the current provisions regarding cost sharing under Medicaid. [1] Below you will find a summary of the new rules as well as the applicable provisions from the Federal Register.

Cost Sharing in General

There are various forms of cost sharing allowed in terms of out of pocket payments that are required of Medicaid participants. Copayments or coinsurance are those fixed charges that participants pay when they receive a service. Deductibles, most commonly found in the commercial market, are specified expenditures that must be incurred before the program or insurer begins to pay for a covered service. Premiums, most commonly in the form of monthly payments, are periodic payments participants must pay to be enrolled for particular health coverage.

Currently, states can choose to require cost sharing in the form of out of pocket costs from Medicaid participants. Such cost sharing requirements are allowed for most Medicaid benefits such as inpatient and outpatient services. Out of pocket costs are not permitted for emergency services, family planning services, pregnancy-related services or preventive services

[1] "Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing: Exchanges, Eligibility and Enrollment" (CMS-2334-F)," Centers for Medicare& Medicaid Services, Federal Register, July 15, 2013.

for children. [2]

New definitions

The new CMS rules can be found at 42 CFR 447.50 through 447.57. New definitions were added to the rules in section 447.51 for "cost-sharing", "inpatient stay" and "outpatient stay". "Non-emergency services" has been defined to mean "any care or services that are not considered emergency services "and does not include "any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment." Section 447.51

Nominal copays

Traditionally, states have only been able to require "nominal" copays from those participants with incomes below 100 percent of the federal poverty level. Most of the out of pocket costs were based on the individual state's payments for a particular service. For instance, if the state paid $10.00 or less for a particular service, the state could charge a maximum copayment of $0.65 and if the state paid $50 or more for a service, the maximum copayment from a participant would be $3.90. [3] The new rules allow for a flat maximum amount of $4 per service. Also of note, is that the maximum cost sharing for the nominal copays for outpatient services and for drugs and non-emergency use of the emergency department shall be increased each year, beginning Oct. 2015, by the percentage increase per the CPI-U, the Consumer Price Index for Urban consumers. Section 447(b)(1); 447.53(b); and 447.54(b)

Prescription drugs

As to prescription drugs, the new rules allow participants to be charged a maximum of $4 for preferred drugs at any income level. Another big change to the rules would allow states to charge $8 copays for non-preferred drugs for participants at or below 150 percent of the federal poverty level. For those with incomes above 150 percent, the cost sharing can go up to 20% of the cost the agency pays for the drug. Section 447.53

Non-Emergency Use of the Emergency Department

States will also be allowed to charge $8 copays for non-emergency use of the

[2] Medicaid.gov "Out of Pocket Costs Exemptions" (2013), **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Exemptions.html**

[3] Medicaid.gov "Cost Sharing Out of Pocket Costs" (2013), **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Cost-Sharing/Cost-Sharing-Out-of-Pocket-Costs.html**

emergency department for those with incomes equal to or less than 150% of the federal poverty level. These participants are currently exempt from such cost sharing. For participants with incomes higher that 150%, there is no limit on the maximum cost sharing for non-emergency use of the emergency department.

If there is not an emergency, hospitals are required to screen and refer the participant to alternative providers. Hospitals shall determine that an alternative provider is available to provide needed services with lesser cost or no cost sharing and they must provide referrals to coordinate scheduling for treatment by such provider. Section 447.54

Targeted Cost Sharing and Denial of Service for Nonpayment

The new rules specify that a state may target cost sharing to specified groups of individuals with family income above 100% of the federal poverty level, specifically to those groups who are enrolled in managed care. The targeting must be based on the eligibility group and not only on the fact that such participant is enrolled in managed care. Section 447.52(d)

The state may permit a provider, including a pharmacy or hospital, to require a participant to pay cost sharing as a condition for receiving the item or service if the participant has income above 100% FPL, the participant is not specifically exempted, and when imposing cost sharing for non-emergency use of the emergency room, the conditions for determining whether such service is or is not an emergency has been met as prescribed under the rules. Section 447.52(e) (1). So, the provider may collect payment from the participant before or after furnishing the service as the participant remains liable to the provider for the payment. However, the state plan shall specify that no provider may deny services to an eligible participant on account of the participant's inability to pay the cost sharing. Section 447.52(e) (2).

Exempt individuals

Under the new rules, certain groups of individuals are exempt from premiums and cost sharing: certain children, pregnant women, American Indians and Alaska Natives, individuals residing in an institution, individuals receiving hospice care and women eligible through the Breast and Cervical Cancer Treatment and Prevention program. Section 447.56

Current Copays in Missouri

Below are the current copay requirements in Missouri and attached is a chart summarizing the cost sharing requirements to be in effect January 2014 under the new rules.

$10.00 Inpatient Hospital Services
$ 3.00 Outpatient or Emergency Room Services (For non-emergency)

$ 1.00 Physician Services
$ .50 Clinic Services
$ 1.00 X-ray and Laboratory Services
$ 1.00 Nurse Practitioner Services
$ .50 CRNA Services
$ 2.00 Rural Health Clinic Services
$ 1.00 Case Management Services
$ 2.00 Federally Qualified Health Care Services
$ 2.00 Psychology Services [4]

[4] MO HealthNet Fee-For-Service Participant handbook page 5-6 (pdf page 7-8) at **http://dss.mo.gov/mhd/participants/pdf/hndbk_ffs.pdf**