DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Centers for Medicaid and State Operations

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act (DRA) of 2005, Public Law Number 109-171. Section 6043, Emergency Room Co-payments for Non-Emergency Care, adds a new subsection 1916A(e), State Option for Permitting Hospitals to Impose Cost Sharing for Non-Emergency Care Furnished in an Emergency Department to the Social Security Act (the Act) and adds a new subsection 1903(y), Payments for Establishment of Alternate Non-Emergency Services Providers to the Act. Subsection 1916A(e) allows the imposition of cost sharing for certain beneficiaries who receive non-emergency services in a hospital emergency room. Subsection 1903(y) authorizes grant funds of $50,000,000 over four years for the establishment of alternate non-emergency services providers. These provisions are effective January 1, 2007.

I. Subsection 1916A(e) – Rules for Emergency Room Copayments for Non-emergency Services

Section 1916A(e) allows States to amend their State plans to allow hospitals to impose cost sharing for an individual (within one or more groups of individuals specified by the State) who receives non-emergency care furnished in the hospital emergency department. In order for the hospital to impose cost sharing:

- The individual must actually have available and accessible an alternate non-emergency services provider with respect to the necessary services.

- The hospital must inform the beneficiary (after the beneficiary has received an appropriate medical screening examination under section 1867 and after a determination has been made that the individual does not have an emergency medical condition) before providing the non-emergency services that:

    - The hospital may require the payment of the State specified cost sharing before the service can be provided;

    - The name and location of an alternate non-emergency services provider that is actually available and accessible;

    - The fact that an alternate provider can provide the services without the imposition of the state specified higher cost sharing for the inappropriate use of the emergency room (nothing under this language should be construed as preventing a state from applying (or waiving) cost sharing otherwise permissible under section 1916A); and

- The hospital provides a referral to coordinate scheduling of this treatment.

Under this provision, the term "non-emergency services" means any care or services furnished in an emergency department of a hospital that the physician determines do not constitute an appropriate medical screening examination or stabilizing examination and treatment required to be provided by the hospital under section 1867 of the Act.

Also, the term "alternative non-emergency services provider" means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider, that can provide clinically appropriate services for the diagnosis or treatment of a condition contemporaneously with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition, and that is participating in the Medicaid program.

Limitations Relating to Cost Sharing

Individuals with Family Income between 100 and 150 percent FPL

For an individual with a family income between 100 and 150 percent of the Federal poverty line, the cost sharing imposed may not exceed twice the amount determined to be nominal under section 1916.

Individuals Exempt under 1916A

In the case of an individual who is otherwise not subject to cost sharing under 1916A(b)(3), a state may impose cost sharing for care in an amount that does not exceed a nominal amount as long as no cost sharing would be imposed to receive the care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved. Below is a list of exempt populations and services not subject to cost sharing under 1916A(b)(3):

- Individuals under 18 years of age that are required to be provided Medicaid under 1902(a)(10)(A)(i), and including services furnished to individuals with whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- Pregnant women, if such services relate to the pregnancy or to any other medical condition, which may complicate the pregnancy.
- Any terminally ill individual who is receiving hospice care.
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the state plan, to spend for costs for medical care all but a minimal amount of the individual's income required for personal needs.
- Women who are receiving medical assistance by virtue of the application of breast or cervical cancer provisions.
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.
- Family planning services and supplies.

Application of Aggregate Cap and Relationship to Other Cost Sharing
Cost sharing applied under this provision is subject to the five percent maximum aggregate cap as applied on a monthly or quarterly basis (as specified by the state).

Cost sharing imposed under this provision shall be instead of any cost sharing that may otherwise be imposed under 1916A(a).

EMTALA and Prudent Layperson Requirements
Nothing in this provision is designed to limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 or to modify any obligations under either State of Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

State Plan Preprints
States may use the enclosed State plan preprint page to adopt this provision. Please submit your SPA electronically in a "pdf" file format to your regional office to implement this provision.

II. Subsection 1903(y) – Grant Funds for Establishment of Alternate Non-emergency Services Providers
Subsection 1903(y) authorizes the payment of $50,000,000 during the four-year period beginning with 2006 to provide payment to states for the establishment of alternate non-emergency service providers or networks of providers. (See above for the definition of an alternate non-emergency service provider.)

In providing for payments to States under this subsection, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of providers that:

- Serve rural or underserved areas where Medicaid beneficiaries may not have regular access to providers of primary care services; or
- Are in partnership with local community hospitals.

Payments to a State under this subsection shall be made upon the filing of a grant application in the form and manner as the Secretary shall specify. More specific requirements will be announced through a *Federal Register* notice and grant submission instructions will be announced on the Web at www.grants.gov.

The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children's Health Program Group, who may be reached at (410) 786-5647 or Jean.Sheil@cms.hhs.gov. If you have any additional questions, please let us know.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

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