Imposition of Cost Sharing Charges Under Medicaid and Supporting Regulations contained in 42 CFR Section 447.53

A. **BACKGROUND**

The purpose of this collection is to ensure that States impose nominal cost sharing charges upon categorically and medically needy individuals as allowed by law and implementing regulations. States must identify in their State plan the service for which the charge is made, the amount of the charge, the basis for determining the charge, the basis for determining whether an individual is unable to pay the charge and the way in which the individual will be identified to providers, and the procedures for implementing and enforcing the exclusions from cost sharing.

B. **Justification**

1. Need and Legal Basis

The information collections described here have been developed due to legislation permitting States to impose cost sharing charges (i.e., copayments, premiums deductibles, coinsurance, and enrollment fees) on medically and categorically needy beneficiaries. In 1972, States were permitted to impose cost sharing on all services provided to the medically needy and on optional services provided to the categorically needy. Section 1916 of the Social Security Act was created by Section 131 of P.L. 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. The amendment removed the restrictions on cost sharing for services furnished to the categorically needy. TEFRA also put into place requirements excluding certain individuals and services from cost sharing: pregnant women, for services related to the pregnancy, certain institutionalized individuals, individuals under 18, emergency and family planning services, and categorically needy individuals receiving services from health maintenance organizations. It also maintained the prior requirement that any cost sharing amounts be nominal for both categorically and medically needy recipients.

As a result, Section 447.53(d) was amended to require States to do the following: (1) set forth procedures on how recipients excluded from cost sharing would be identified to

providers; and (2) specify in its State plan the procedures for implementing and enforcing the exclusions from cost sharing found in Section 447.53(b). This Section requires that for each charge imposed, 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 method used to collect the charge;

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

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

The following is an item-by-item justification for the requirements specified above. The first three items have been required since 1974.

1. The service for which a charge is imposed must be identified to assure that the service is not one of the services excluded from cost-sharing. For each service identified (e.g., physical examination, x-ray, lab work, etc.,) the State agency will answer questions 2 through 4.

2. States must report the cost-sharing amount charged for each service so that CMS can assess if the charge is nominal.

3. Because Federal guidelines provide the States with various options (such as fixed amount or percentage basis) for determining co-payment charges, the States must identify the basis they use for determining the charge.

4. Since States are given the option to decide how cost sharing charges will be collected, the State must specify the method they use to collect the charge. States have the option of collecting the charge from the recipient or requiring the provider to collect the charge from the recipient.

5. At this time there are no Federal guidelines that direct

States on how to identify individuals who are unable to pay the cost sharing charge. We believe that the State's administrative burden for complying with this requirement will be lessened, if States are permitted to institute their own procedures. States are required, however, to report to CMS how they will identify individuals who cannot pay. This single description will apply to all services on which there is cost sharing.

6. Although States are required to specify their procedures for implementing and enforcing the statutory exclusions from cost sharing, no Federal guidelines have been adopted that must be followed by States. We believe that this provision gives States flexibility to accommodate the substantive differences in their systems. States are required to report to CMS their procedures for handling exclusions. This is a single reporting requirement which will apply to all services which have cost sharing.

We have also taken into consideration the possibility of States providing assurances that state they will comply with regulatory and statutory provisions. However, given the numerous possibilities under the cost-sharing rules, it would not be enough simply to obtain assurances from the State that say these rules are being followed. Within these rules are a variety of options and program alternatives that must be recorded within the framework of the State's plan, in order to ensure compliance. For example, on any service (such as prescription drugs) a State may have no cost sharing, impose a copayment under the maximum, impose a coinsurance, base its charge on the actual reimbursement rate for each service, or base its charge on the average payment for the services. Due to the various methods of determining a cost sharing charge a simple assurance would not suffice and would possibly make for deficient implementation of the cost sharing provisions.

2. Information Users

The information users are the Regional Offices and CMS. This information collection assures that States are complying with the statute. The Medicaid agency is responsible for developing and submitting the required information in the State plan. This information is reviewed and approved by the Regional Office. If the Regional Office finds the plan provisions unacceptable, they are submitted to Central Office for review and disposition. The State plans are maintained by the

Regional Office.

3. Improved Information Technology

Usually the States submit the information in a preprinted form designed by CMS. States indicate the provisions of the Medicaid program by either checking or filling in the preprinted forms. Because the information is submitted in a preprinted text, this cuts down on the time it takes the State to report the information. We note that all States have been participating in Medicaid Statistical Information System (MSIS) since 1999. The States submit information on their State plan electronically.

4. Duplication of Similar Information

These information collection requirements are unique to the Medicaid program. All Medicaid State Agencies that elect to impose cost sharing are required to submit specific information in their State plan and to amend the plan as necessary. There is no duplication of this information. There are no other Federal agencies or alternative sources that can provide this information or similar information.

5. Small Businesses

These requirements do not affect small businesses. Only State Medicaid agencies must comply with these requirements.

6. Less Frequent Collection

State plans are a one-time data collection, unless State or Federal policy changes require revisions to the plan.

7. Special Circumstances

These requirements comply with all general information collection guidelines in 5 CFR 1302.6

8. Federal Register Notice/Outside Consultations

A 60-day Federal Register notice was published on 3/23/2007.

During the development of 42 CFR 447.53, CMS was in contact with the Medicaid State agencies, providers, and special interest groups.

9. Payment/Gift to Respondent

There is no payment or gift to respondent.

10. Confidentiality

This information is not confidential.

11. Sensitive Questions

There are no sensitive questions.

12. Burden Estimate (Total Hours and Wages)

We anticipate that no more than 2 States will amend their State plans and that it will take them approximately 10 hours, for a total annual burden of 20 hours.

13. Capital Costs (Maintenance of Capital Costs)

There are no capital costs.

14. Cost to Federal Government

There will be no additional cost to the Federal government for implementing and imposing the regulatory requirements. Costs will be incurred when the State plan is submitted for Federal review and approval.

15. Burden/Program Changes

There are no burden or program changes.

16. Publication and Tabulation Data

There are no publication or tabulation data.

17. Expiration Date

CMS does not use any forms with this collection that show an expiration date.

18. Certification Statement

There are no exceptions to the certification statement.

C. Collection of Information Employing Statistical Methods

This information collection does not employ statistical methods.