G2c - Cost Sharing Amounts – Targeting

Statute: 1916, 1916A
Regulation: 42 CFR 447.52 - 447.54

INTRODUCTION

This state plan page (fillable PDF) G2c is used to indicate if the state targets cost sharing charges (deductibles, co-insurance or co-payments) to specific groups of individuals covered under the state plan, and if so, the provisions for administering targeted cost sharing. Non-targeted cost sharing imposed on categorically and medically needy individuals are covered in separate state plan pages (G2a for categorically needy and G2b for medically needy).

State plan page G2c need only be submitted when changes are being proposed to provisions contained on page G2c.

BACKGROUND

For background information related to the cost sharing state plan pages, including state plan page G2c, please see separate Implementation Guide, titled "Background - Medicaid Cost Sharing."

TECHNICAL GUIDANCE

PREREQUISITES:

If the state is proposing to establish new targeted cost sharing or modify existing targeted cost sharing in the state plan, it must submit the following pages prior to or concurrently with state plan page G2c. These prerequisites do not apply to states proposing to discontinue cost sharing currently charged to targeted populations under the state plan.

- **G1 - Cost Sharing Requirements**
- **G3 - Cost Sharing Limitations**

This state plan page is divided into 3 major sections:

- Option for Targeting Cost Sharing to Specific Groups of Individuals
- Cost Sharing For Non-Preferred Drugs Charged to Otherwise Exempt Individuals
- Cost Sharing For Non-Emergency Services Provided in the Emergency Department (ED) Charged to Otherwise Exempt Individuals

Review Criteria

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

G2c - Cost Sharing Amounts – Targeting

Option for Targeting Cost Sharing to Specific Groups of Individuals

The state must first indicate ***Yes*** or ***No*** as to whether it targets cost sharing to a specific group or groups of individuals.

If a state currently charges cost sharing to other populations in addition to targeted cost sharing and wants only to discontinue targeted cost sharing currently charged under the state plan, they should submit G2c and indicate ***No***. If a state wants to discontinue all cost sharing currently imposed under the state plan, the state need submit only state plan page G1 and no other state plan page.

States modifying existing cost sharing or proposing to impose cost sharing under 1916A authority (i.e. targeted cost sharing charged to specified eligibility groups with incomes greater than 100% of the FPL) must select ***Yes***. States currently imposing or proposing to impose cost sharing under both 1916 and 1916 A authority (i.e. nominal cost sharing charged to all categorically and/or medically needy individuals and also higher than nominal cost sharing charged to specified eligibility groups with incomes greater than 100% of the FPL) must also select ***Yes*** to this question**.**

If ***No,*** no additional information is requested. If the state selects ***Yes,*** that is the state targets cost sharing to specific groups of individuals, additional text is displayed for the state to provide specifics regarding targeted cost sharing.

Note: States may not target cost sharing to specific groups of individuals with incomes equal to or less than 100% FPL. This state plan page is used only for targeting cost sharing to specific groups of individuals with incomes greater than 100% FPL.
The following subsections must be completed for each targeted group:

Targeting Criteria

This section begins with, at state option, entry of a name for the population being targeted.

A population is a group of individuals that has the exact same cost sharing provisions. If cost sharing amounts vary by eligibility group(s) and/or family income, each combination of eligibility groups and/or income ranges with different cost sharing amounts are considered as separate populations. If a state targets more than one population, the information for each population must be entered separately. Populations/Eligibility Groups can be added by clicking on the "Add Population" button on the bottom left hand corner immediately below the section of the last population entered. To remove a population, click on the "Remove

Population" button located on the bottom right corner of the section of the population to be removed.

The state must then enter the name(s) of the eligibility group(s) and income range of the targeted population. The name(s) of the eligibility group(s)s should correspond to the names of the eligibility group(s) covered under the state plan and must not include eligibility groups which are exempt from cost sharing.

Review Criteria

The state must enter the names of the eligibility group(s) being targeted and must not include an exempt eligibility group(s) or this state plan page cannot be approved.

Next, the state must enter the income range being targeted.

There are two fields to enter the income range, labeled "Incomes Greater than" for the lower end of the income range and "Incomes Less than or Equal to" for the upper bound of the income range. In these fields, the state enters the Federal Poverty Level (FPL) percentages or dollar amounts for household income of the targeted group. For entry of FPL levels, the state should include the percentage symbol (%) and "FPL" to the right of the number entered in the fields (e.g. 150% FPL). For dollar entries, the state should include the dollar sign ($) to the left of the number entered in the field (e.g. $700). For dollar entries, the state should enter if it is per month, quarter, year, etc. ($700/month).

Note: When using FPL levels, "Incomes Greater than" (i.e. the lower end of the income range) should be read to mean the dollar amount represented by the FPL percentage entered plus one cent (e.g. if 100% FPL for a family of 2 equals $15,510, 100% in the "Incomes Greater than" field means $15,510.01). This same rule applies to dollar amounts entered in this field (e.g. $700 entered in the "Incomes Greater than" field should be read to mean $700.01). The one exception to this is for states whose lowest income range starts at zero. In this case the first entry for "Incomes Greater than "should be 0 (zero) and read as zero and not as one cent.

"Incomes Less than or Equal to" (i.e. the upper end of the income range) should be read to mean the actual dollar amount entered or the dollar amount represented by the FPL percentage. For example, if 100% FPL for a family of 2 equals $15,510, 100% FPL entered for "Incomes Less than or Equal to" means $15,510.

If the highest income level of the target population does not have an upper bound (e.g. the income range is greater than 150% FPL or greater than $700, with no upper limit then enter "No upper limit" in the "Incomes Less than or Equal to" field.

Review Criteria

The state must enter the targeted income range or this state plan page cannot be approved. If the state uses FPL percentages for family income, the FPL entered for "Incomes Greater than" must not be less than 100% FPL and the FPL entered for "Incomes Less than or Equal to" must be greater than that entered for "Incomes Greater than" or "No upper limit" or this state plan page cannot be approved. If the state uses dollar amounts for family income, the dollar amount entered for "Incomes Greater than" must not equal less than 100% of the FPL and the dollar amount entered for "Incomes Less than or Equal to" must be greater than that entered for "Incomes Greater than" or "No upper limit" or this state plan page cannot be approved. As the Federal Poverty Level increases each year, the state must ensure that if a dollar amount is used for the lower bound of the income range, it remains at greater than 100% of the FPL.

Next, the state must enter the specifics of the cost sharing for the eligibility group entered, including services; amounts; dollars or percentage; unit of service; and other relevant information in the cost sharing table.

Cost Sharing Table

Each service or item for which cost sharing will be charged and its corresponding information must be entered on a separate row. Rows can be added by clicking on the + (plus) sign on the left side of a row. To remove rows, click on the "***X***" key on the right side of the row. Please see section labeled "Instructions for Required Information" below.

If the cost sharing amount varies by the cost of the service or item, re-enter the service or item on a separate row for each cost sharing amount. The cost of the service or item to which the cost sharing applies should be written to the right of the name of the service or item. See example 1.

Example 1

Service or item	Amount	Dollars or Percentage	Unit
Office Visit reimbursed at $30 or less	2.00	$	Per Visit
Office Visit reimbursed at more than $30	4.00	$	Per Visit

If the state does not vary the cost sharing charge based on what the agency pays for the service, the state must include in the explanation column the average amount the agency

pays for the service or item. The amount of cost sharing for individuals with income great than 100% FPL but at or below 150% of the FPL must not exceed 10% of what the agency pays for the service. The amount of cost sharing for individuals with income great than 150% of the FPL must not exceed 20% of what the agency pays for the service. See Example 2

Note: For non-preferred drugs, the cost sharing is limited to nominal amounts as defined in the regulation at 42 CRF 447.53 for individuals with income at or below 150% of the FPL, and 20% of what the agency pays for individuals with income over 150% of the FPL. For non-emergency services provide in a hospital ED, there is no limit on the cost sharing for individuals with income greater than 150% of the FPL, other than the fact that the cost sharing cannot be equal to or more than what the agency pays for the service and premiums and cost sharing for all services have a 5% of family income aggregate limit).

Example 2

Service or item	Amount	Dollars or Percentage	Unit	Explanation
Office Visit	6.00	$	Per Visit	The average reimbursement for office visits is $65
Laboratory	7.00	$	Per Visit	The average reimbursement for laboratory is $85

For review criteria, please see section titled “Review Criteria for Cost Sharing Specifics” below.

Requiring Payment as Condition to Receiving Services

The state must first indicate ***Yes*** or ***No*** as to whether it permits providers to require non-exempt individuals with family income above 100% FPL to pay cost sharing as a condition of receiving items or services.

Review Criteria

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

If ***Yes,*** the state must then indicate ***Yes*** or ***No*** to as to whether providers may require payment of cost sharing as a condition for receiving all items or services for which cost sharing is charged.

G2c - Cost Sharing Amounts – Targeting

Review Criteria

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

If the state answers ***No,*** and providers may require payment of cost sharing as a condition for receiving some, but not all, items or services for which cost sharing is charged, the state must then list the services for which providers may require payment of cost sharing as a condition of receiving the service or item.

Review Criteria

At least one service or item must be entered or this state plan page cannot be approved.

Cost Sharing for Non-Preferred Drugs Charged to Otherwise Exempt Individuals

States charging cost sharing for non-preferred drugs to the targeted group(s) must indicate ***Yes*** or **No** as to whether the state charges cost sharing for non-preferred drugs to otherwise exempt individuals.

States not charging cost sharing for non-preferred drugs to the targeted group(s) need not answer this question.

If ***Yes***, The state must then indicate ***Yes*** or ***No*** as to whether the cost sharing charges for non-preferred drugs imposed on otherwise exempt individuals are the same as the charges for non-preferred drugs imposed on the non-exempt individuals.

Review Criteria

States which entered amounts higher than the maximum at 42 CFR 447.53(Individuals with Family Income < 150% of the FPL) cannot indicate Yes and must select No to the question of whether the cost sharing charges for non-preferred drugs imposed on otherwise exempt individuals are the same as the charges imposed on the non-exempt individuals or this state plan page cannot be approved.

If the state answers ***No*** to the second question, the state must then enter the information requested in the table: amount; dollar or percentage; unit of service or item; and explanation. For instructions on completing the table, please see section labeled “Instructions for Required Information” below.

If the cost sharing amount varies by what the agency pays for the drug, each range with different cost sharing amounts should be entered on a separate row. The amount the agency pays for the

drug to which the cost sharing applies should be written in the explanation column, e.g. “per non-preferred drug for which the agency pays less than $40”.

For review criteria, please see section titled “Review Criteria for Cost Sharing Specifics” below.

Cost Sharing for Non-emergency Services Provided in the ED Charged to Otherwise Exempt Individuals

States charging cost sharing for non-emergency services provided in the ED to the targeted group(s) must answer the next question by indicating ***Yes*** or ***No*** as to whether the state charges cost sharing for non-emergency services provided in the ED to otherwise exempt individuals.

States not charging cost sharing for non-emergency services provided in the ED to the targeted group(s) need not answer this question.

If ***Yes***, the state must then indicate ***Yes*** or ***No*** as to whether the cost sharing charges for non-emergency services provided in the ED imposed on otherwise exempt individuals are the same as the charges for non-emergency services provided in the ED imposed on the non-exempt individuals.

Review Criteria

States which entered amounts higher than themaximum at 42 CFR 447.54(Individuals with Family Income < 150% of the FPL) cannot indicate Yes and must respond No to the question of whether the cost sharing charges for non-emergency services provided in and ED imposed on otherwise exempt individuals are the same as the charges s imposed on the non-exempt individuals or this state plan page cannot be approved.

If the state answers ***No*** to the second question**,** the state must then enter the information requested in the table: amount; dollar or percentage; unit for the service or item; and explanation. For instructions on completing the table, please see section labeled “Instructions for Required Information” below.

If the cost sharing amount varies by what the agency pays for the service, each range with different cost sharing amounts should be entered on a separate row. The amount the agency pays for the service to which the cost sharing applies should be written in the explanation column, e.g. “per non-emergency service for which the agency pays less than $40”.

For review criteria, please see section titled “Review Criteria for Cost Sharing Specifics” below.

G2c - Cost Sharing Amounts – Targeting

Instructions for Required Information

The state must first enter the name of the individual service or item to which cost sharing applies.

Note: To the extent possible, and if applicable, names entered for services or items should be as specific as possible and not the broader benefit name under which the service or item is categorized. For example, if the cost sharing charge is imposed for eyeglasses, then the service or item is eyeglasses and not vision services. Likewise if the cost sharing is imposed for certain dental services or items, such as dentures or crowns, the service or item is dentures or crowns and not dental services.

After entering the name of the benefit or service or item:

- Enter the cost sharing charge (amount) for that service or item;
- Select either dollars or percentage associated with the amount entered from the drop down list in the dollars or percentage column;
- Select the applicable unit for the service or item from the drop down list in the unit column; and
- Enter information in the explanation column that is pertinent to the state's imposition of cost sharing to this population for the service or item, including but not limited to, the average amount the agency pays for the service or item, whether any aggregate limits apply to that benefit (for example, cost sharing for preferred drugs will not exceed $15 in a month). If "Other" was selected as the unit for the service or item, the state must enter a name for, or explanation of the "Other" unit used for the service or item.

Example 4

Service or Item	Amount	Dollars or Percentage	Unit	Explanation
Preferred Drugs	2.00	$	Other	Unit=1 month supply; Preferred Drugs aggregate limit = $15/month.

Review Criteria for Cost Sharing Specifics

For each targeted group, the state must include all the services or items for which the state charges cost sharing. At least one service or item must be entered.

The cost sharing amount and whether the charge is a percentage or dollar amount must be indicated for each service or item entered.

The cost sharing amounts entered must be within the regulatory maximum allowable amounts as described in 42 CFR 447.52 (Individuals with Family Income 101-150% of the FPL and Individuals with Family Income >150% of the FPL) for inpatient and outpatient services;

G2c - Cost Sharing Amounts – Targeting

447.53(Individuals with Family Income < 150% of the FPL for otherwise exempt populations and Individuals with Family Income >150% of the FPL for non-exempt population) for prescribed drugs; and 447.54 (Individuals with Family Income < 150% of the FPL for otherwise exempt populations and Individuals with Family Income >150% of the FPL for non-exempt population) for non-emergency services provided in the ED or this state plan page cannot be approved.

The Unit used for the service or item must be indicated. If "Other" was selected as the unit of service or item, an explanation of the unit used must be included in the explanation column. The average cost of the service or item and benefit aggregate limit, if applicable, must also be entered in the explanation column.

All the elements of the review criteria must be met or this state plan page cannot be approved.