

Application to Use Burden/Hours from Generic PRA Clearance: Medicaid and CHIP State Plan, Waiver, and Program Submissions

CMS-10398 (#29), OCN 0938-1148)

(Formerly CMS-R-53, OCN 0938-0429)

Information Collection #29 Medicaid Cost Sharing

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Center for Medicaid and CHIP Services (CMCS)
Centers for Medicare & Medicaid Services (CMS)

CMS-R-53 had been formerly approved under OCN 0938-0429.

A. Background

The Centers for Medicare & Medicaid Services (CMS) work in partnership with States to implement Medicaid and the Children's Health Insurance Program (CHIP). Together these programs provide health coverage to millions of Americans. Medicaid and CHIP are based in Federal statute, associated regulations and policy guidance, and the approved State plan documents that serve as a contract between CMS and States about how Medicaid and CHIP will be operated in that State. CMS works collaboratively with States in the ongoing management of programs and policies, and CMS continues to develop implementing guidance and templates for States to use to elect new options available as a result of the Affordable Care Act or to comply with new statutory provisions. CMS also continues to work with States through other methods to further the goals of health reform, including program waivers and demonstrations, and other technical assistance initiatives. States and the Centers for Medicare & Medicaid Services (CMS) share responsibility for operating Medicaid programs consistent with title XIX of the Social Security Act and its implementing regulations. Together, the federal and state governments share accountability for the integrity of the total investment of dollars in the Medicaid program and the extent to which that investment produces value for beneficiaries and taxpayers

B. Description of Information Collection

The purpose of this collection is to ensure that States impose cost sharing charges upon Medicaid beneficiaries as allowed by law and implementing regulations. States must identify in their State plan the service for which the charge is made; the group or groups of individuals that may be subject to the charge; the amount of the charge; the process used by the state to identify for providers whether cost sharing may be imposed and whether or not a provider may require payment of the cost sharing as a condition of receiving the item or service; and the procedures for implementing and enforcing the exclusions from cost sharing. If the state imposes cost sharing for non-emergency use of the emergency department, the state must indicate the process for identifying emergency room services as non-emergency.

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).

Section 1916A of the Act was created as a result of the Deficit Reduction Act of 2005 to allow states to impose alternative, higher cost sharing and premiums for individuals with income over 100% of the FPL. Under this law, and implementing regulations, premiums and cost sharing could not exceed 5% of family income. As a result, 42 CFR 44.68 was added to require states to do provide the following information in the state plan:

- 1) The group or groups of individuals that may be subject to the cost sharing charge,
- 2) The methodology used to determine family income, for purposes of the limitations on cost sharing related to family income, including the period and periodicity of those determinations,
- 3) The item or service for which the charge is imposed, and the amount of the charges.
- 4) The methodology used by the state to identify beneficiaries who are subject to premiums or cost sharing; whether the family is at risk of reaching the 5% aggregate limit; tracking beneficiaries incurred premiums and cost sharing in a manner that does not rely on beneficiaries; inform recipients and providers of their liability, and notifying recipients and providers when individual recipients have reached their aggregate limit.
- 5) The process for informing recipients, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals.
- 6) The methodology used to ensure that:
 - (a) The aggregate amount of premiums and cost sharing imposed under section 1916 or section 1916A of the Act for individuals with family income above 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.
 - (b) The aggregate amount of cost sharing under sections 1916, 1916A(c), and/or 1916A(e) of the Act for individuals with family income at or below 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.
- 7) The notice of, time frame for, and manner of required cost sharing and the consequences for failure to *pay*.

On July 15, 2013 all regulations implementing sections 1916 and 1916A of the Act (447.50-82) were revised and significantly revised down to 447.50-57. As a result, 447.52 was revised to require the state plan to contain the following information for each charge imposed:

- 1) The service for which the charge is made;
- 2) The group or groups of individuals that may be subject to the charge;
- 3) The amount of the charge;
- 4) The process used by the state to—
 - (a) Ensure individuals exempt from cost sharing are not charged,

- (b) Identify for providers whether cost sharing for a specific item or service may be imposed on an individual and whether the provider may require the individual, as a condition for receiving the item or service, to pay the cost sharing charge; and
- 5) If the agency imposes cost sharing under §447.54, the process by which hospital emergency room services are identified as non-emergency service.

The following is an item-by-item justification for the requirements specified above. Some of these 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 indicate the group or groups of individuals that may be subject to the charge so CMS know whether all individuals in the state plan are subject to the charge or just some.
- 3) States must report the cost-sharing amount charged for each service so that CMS can assess if the amount is within the maximum amount allowed by statute and regulation.
- 4) Although States are required to specify their procedures for implementing and enforcing the statutory/regulatory exclusions from cost sharing, and to indicate the process used to identify for providers whether cost sharing for a specific item or service may be imposed on an individual and whether the provider may require the individual, as a condition for receiving the item or service, to pay the cost sharing charge; and, 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, and informing providers of what cost sharing is permitted. Procedures for implementing the exclusions is a single reporting requirement which will apply to all services which have cost sharing. Whether or not a provider can require payment of cost sharing as a condition of receiving the item or service is only relevant if the state is imposing targeted cost sharing on individuals over 100% of the FPL.
- 5) If the agency imposes cost sharing for non-emergency use of the emergency department, it must indicate the process by which hospital emergency room services are identified as non-emergency service. This information is needed so CMS can determine that the state meets the requirements of the statute and regulations related to imposing this particular type of cost sharing.

C. Deviations from Generic Request

No deviations are requested.

D. Burden Hour Deduction

The total approved burden ceiling of the generic ICR is 86,240 hours, and CMS previously requested to use 45,948 hours, leaving our burden ceiling at 40,292 hours. CMS estimates that each State will complete the collection of data and submission to CMS within 5 hours. There is a potential universe of 10 responses (aggregate) per year, so the total burden deducted from the total for this request is 50 hours.

E. Timeline

Not applicable. This is an extension (without change) of a currently approved GenIC.