Medicaid Premiums and Cost Sharing

State Name: Iowa

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Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

☑ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).

☑ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:

- ☑ 133% FPL; and
- ☑ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.

☑ Disabled or blind individuals under age 18 eligible for the following eligibility groups:

- ☑ SSI Beneficiaries (42 CFR 435.120).
- ☑ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
- ☑ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).

☑ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.

☑ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

☑ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.

☑ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

☑ An individual receiving hospice care, as defined in section 1905(o) of the Act.

☑ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

☑ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ◉ Under age 21
- ○ Other reasonable category

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. Yes

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☒ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☒ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☒ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☒ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☒ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☒ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews
  - ☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document
  - ☒ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☒ Other procedure

Description:

If an applicant answers yes to the following question on the single streamlined application, cost-sharing is waived: "Has this person ever gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs?"

Additional description of procedures used is provided below (optional):

☒ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

MCOs are required to develop mechanisms, subject to State review and approval, to identify individuals exempt from cost sharing.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

The percentage of family income used for the aggregate limit is:

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

The state calculates family income for the purpose of the aggregate limit on the following basis:

- (●) Quarterly
- ( ) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **No**

Explain why the state's premium and cost sharing rules do not place beneficiaries at risk of reaching the aggregate family limit:

> Beneficiaries are not at risk of reaching the aggregate family limit given the low amount of cost-sharing imposed and because the State does not impose cost sharing on individuals below 50% FPL. As demonstrated in data provided to CMS, 0.5% of individuals reached the 5% cap. Therefore, in accordance with 42 CFR 447.56, the State does not apply a process to track incurred cost sharing that does not rely on beneficiary documentation. Individuals receive notice of their right to appeal if they exceed the 5% cap.
>
> For managed care enrollees, managed care organizations (MCOs) are contractually required to develop mechanisms to track cost sharing to ensure members' total cost sharing does not exceed 5% of quarterly household income. Further, they must ensure that if the 5% limit is reached, cost sharing is no longer collected until the beginning of a new quarter and the provider's reimbursement is adjusted accordingly so that co-payment amounts are no longer deducted from claims reimbursement. The State reviews and approves the MCO's methodologies for compliance.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

> MCOs are contractually required to operate a grievance and appeal process. Managed care enrollees have the opportunity to appeal to their MCO and if dissatisfied with the outcome of the MCO appeal process can file an appeal with the State through the State Fair Hearing process.
>
> Individuals enrolled in fee-for-service can file an appeal directly with the State through the State Fair Hearing process.

Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

> For managed care enrollees, MCOs reimburse beneficiaries and adjust claims to providers in the event a family is identified as paying over the aggregate limit. The State reviews and approves the MCO's methodologies for compliance.

Under fee-for-service, beneficiaries may bring receipts to the Medicaid agency to demonstrate that they have paid cost-sharing in excess of the aggregate limit for the quarter. The Medicaid agency will review the receipts and reimburse beneficiaries for any amount above the aggregate limit.

☒ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

At any time, beneficiaries may notify the Medicaid agency of a change in their income or other circumstance that might change their aggregate cost-sharing limit. Once a beneficiary notifies the Medicaid agency of such change, the Medicaid agency will review the updated information and change the aggregate limits, if necessary.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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