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?"

Additionally, the following procedures are in place to identify the AI/AN exemption:
• Information collected within the Eligibility & Enrollment (E&E) system, based on what the applicant indicates on the single streamlined application.
• Information is passed to post-E&E systems, which are the Title XIX (TXIX) and Medicaid Management Information System (MMIS) systems;
> TXIX – Receives eligibility information from E&E systems and generates eligibility files that are passed to MMIS.
> MMIS – Eligibility information is updated into the Recipient data of the MMIS, which enables the MMIS to set a flag.
• MMIS then uses this internally for setting the appropriate flags to insure that an applicant's cost-sharing is waived, when appropriate under these circumstances involving AI/AN.
• This information is made available to providers, via ELVS and the online electronic eligibility (HIPAA-compliant) portal.
• For members enrolled in an MCO, the member eligibility information is passed to the MCOs from the MMIS.

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.

The Eligibility & Enrollment (E&E) system passes the flags to the post-eligibility systems in the same way that it does so for the AI/AN exemption.

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

Relative to identifying all other individuals exempt from cost-sharing by use of a list of procedures, including MMIS flags, to identify members exempt from cost-sharing AND what triggers those flags in MMIS, different copay exemptions would be triggered differently, related to each exemption. For instance, for exemptions related to receipt of family planning services, an "FP" indicator is used, which identifies the service as being exempt from cost-sharing because it involves FP services. In cases of copays not being charged for children under 21 years of age, the "flag" would be tied to system logic which calculates the member's age by the birthdate on file for that member.

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 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. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

The eligibility system calculates the 5% cost sharing limit based on household size and income. This is then sent via a daily file to the MMIS which transmits the data to the MCOs. MCOs send daily files to the MMIS identifying all copayments applied. The MMIS then tracks and accumulates cost sharing totals, inclusive of premiums and copayments. If the 5% limit is reached, notification is sent to the enrollee informing them the cost sharing limit has been met and no additional cost sharing will be applied. This is sent by the MCO for managed

care enrollees and MMIS for fee-for-service (FFS). The MCO then updates claims processing for the remainder of the month to ensure the copayment is not deducted. The MMIS completes the same for FFS claims.

☐ Other process:

☑ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Once the aggregate family limit has been met, the MCO (for managed care) or MMIS (for FFS) sends notice to the beneficiary that the limit has been met and cost sharing will not apply for the remainder of the month. Providers are informed through the eligibility verification systems.

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:

Managed care enrollees may bring receipts to the MCO and 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 month. The MCO or Medicaid agency, as applicable, will review the receipts and reprocess any claims in which excess cost sharing was charged to the member or beneficiary. The MCOs and Medicaid agency also provide additional guidance to providers informing them that if a copay was collected, the provider is required to process a reimbursement of that cost sharing amount to the beneficiary.

☑ 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:

Managed care members may bring receipts to the MCO and 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 month. The MCO or Medicaid agency, as applicable, will review the receipts and reprocess any claims in which excess cost sharing was charged to the member or beneficiary. The MCOs and Medicaid agency also provide additional guidance to providers informing them that if a copay was collected, the provider is required to process a reimbursement of that cost sharing amount to the beneficiary.

☑ 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

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