DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

June 16, 2006 SMDL #06-015

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA). The DRA (Public Law 109-171) through sections 6041, 6042, and 6043, provides State Medicaid agencies with a new option to impose premiums and cost sharing upon certain Medicaid recipients. These sections of the DRA inserted a new section 1916A in the Social Security Act (the Act) which sets forth options for alternative premiums and cost sharing that are not subject to the limitations under section 1916 of the Act, including cost sharing for non-preferred prescription drugs, and cost sharing for non-emergency use of a hospital emergency room. (Alternative cost sharing for non-emergency use of a hospital emergency room under section 6043 will be addressed in a subsequent State Medicaid Director's letter). We plan to apply the limitation of section 1916 to beneficiaries at or below 100 percent of the Federal Poverty Level (FPL). Further guidance will be provided through the rulemaking process.

Rules for Premiums and Cost-Sharing under Section 1916A(a), (b) and (d) (Effective Date: March 31, 2006)--(For Rules Governing Cost-Sharing for Prescription Drugs under Section 1916A(c) – see information included on page 4)

Under the new section 1916A, States have a new option to impose premiums upon any group of non-exempt individuals (with family incomes over 150 percent of the FPL) as specified by the State in their State plans, and cost sharing upon any group of non-exempt individuals (with family income over 100 percent of the FPL) and for any non-exempt services as specified by the State in its State plan. A listing of exempt groups of individuals and exempt services for which no cost sharing is permitted is specified below. For example, States may impose premiums upon all non-exempt childless adults (with family incomes over 150 percent of the FPL) or States may impose cost sharing for non-exempt items and services to individuals in the section 1931 eligibility group with family incomes between 100 and 200 percent of the FPL. States may vary the premiums and cost sharing among the groups of individuals or types of items and services they select in their State plan, subject to the limitations described below.

Limitations on Premiums and Cost Sharing under Section 1916A

1. Non-Exempt Individuals with Family Income Above 100 Percent but At or Below 150 Percent of the FPL

A. Premium Rules

States may not impose premiums under the State plan.

B. Cost Sharing Rules

Cost sharing may not exceed 10 percent of the cost of the item or service.

C. Aggregate Cap

Total cost sharing, including cost sharing for prescription drugs and non-emergency use of emergency rooms, may not exceed 5 percent of the family income, as applied on a monthly or quarterly basis, as specified by the State.

2. Non-Exempt Individuals with Family Income Above 150 Percent of the FPL

A. Premium Rules
States may impose premiums.

B. Cost Sharing Rules
Cost sharing may not exceed 20 percent of the cost of the item or service.

C. Aggregate Cap
Total premiums and cost sharing, including cost sharing for prescription drugs and non-emergency use of emergency rooms, may not exceed 5 percent of the family income, as applied on a monthly or quarterly basis, as specified by the State.

3. Exempt Populations - Premiums
No premiums shall be imposed for the following individuals:

- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under Part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

4. Exempt Services – Cost Sharing
No cost sharing shall be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under Part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of such title, without regard to age;

• Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
• Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
• Services furnished to a terminally ill individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
• Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
• Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
• Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
• Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions).

5. Additional Exemptions

States may exempt additional groups of individuals from premiums or additional items or services from cost sharing. States also may further reduce the premiums and cost sharing below the limitations specified by the law.

Determination of Family Income

Family income shall be determined in a manner, and for such period, and at such periodicity as specified by the State. For purposes of cost sharing determinations, States may use gross income. States do not need to use the same income methodology for the purposes of determining eligibility as they do for determining premiums and cost sharing.

Ensuring that Premiums and Cost Sharing Do Not Exceed Aggregate Cap

The State plan must describe how the State will ensure that the aggregate premium and/or cost sharing amounts do not exceed 5 percent of such family's income for the monthly or quarterly period.

Enforceability of Premiums and Cost Sharing

Section 1916A(d) allows States to enforce the payment of premiums (if applicable) and cost sharing for certain Medicaid beneficiaries.

1. Enforceability of Premiums

For non-exempt individuals with family income above 150 percent of the FPL, States may condition Medicaid eligibility upon prepayment of the premium under section 1916A or States may terminate eligibility for Medicaid because of failure to pay such a premium; however, such termination cannot occur until the failure to pay such premium has continued for a period of 60 days or more. A State plan must specify the group or groups of individuals to which the prepayment or termination options apply. A State may also waive payment of a premium in any case where it determines that requiring the payment would create an undue hardship.

2. Enforceability of Cost Sharing

Under section 1916A, States may permit a provider participating under the State plan to require, as a condition for the provision of covered care, items, or services to a Medicaid-eligible individual, the individual to pay the cost sharing amount authorized under section 1916A. A State electing this option must indicate so in its State plan. The provider is not prohibited by this authority from choosing to reduce or waive cost sharing on a case-by-case basis.

Waivers

Sections 1916A(b)(6)(B) and 1916A(b)(6)(C) clarify that section 1916A does not affect any waiver granted before the enactment of the DRA, with regard to the implementation of premiums and cost sharing, and that nothing in the section affects the Secretary's waiver authority.

Effective Date

This provision became effective March 31, 2006. States must submit a State plan amendment (SPA) to implement cost sharing. We have attached a SPA template for your convenience. SPA submissions should be submitted electronically in a "pdf" file format.

Special Rules for Cost Sharing for Prescription Drugs under Section 1916A(c) (Effective March 31, 2006)

Section 6042 of the DRA adds a new section 1916A(c), Special Rules for Cost Sharing for Prescription Drugs, which provides States with additional options for establishing cost sharing requirements for drugs to encourage the use of preferred drugs. Preferred drugs are those identified by the State as the least (or less) costly effective prescription drugs within a class of drugs (as defined by the State), with respect to one or more groups of beneficiaries specified by the State.

Under this provision, States may require increased cost sharing for drugs that are not preferred drugs within a class and waive or reduce the cost sharing otherwise applicable for preferred drugs within such class. States shall not apply any cost sharing for preferred drugs for individuals for whom cost sharing may not otherwise be imposed under the rules of section 1916A(b)(3)(B). (See page 2 – "Exempt Populations – Premiums" for the list of affected groups.) States have the flexibility to include or exclude specified drugs or classes of drugs from this provision.

Cost Sharing Limits

- In the case of individuals whose family income does not exceed 150 percent of the FPL, the amount of cost sharing for non-preferred drugs may not exceed the amount of nominal cost sharing as defined in section 1916.

- In the case of individuals whose family income exceeds 150 percent of the FPL, the amount of cost sharing for non-preferred drugs may not exceed 20 percent of the cost (Medicaid payment amount) of the drug.

- In the case of an individual who is otherwise not subject to cost sharing as a result of section 1916A(b)(3)(B), any cost sharing for non-preferred drugs may not exceed a nominal amount as defined in section 1916.

- Any cost sharing applied to an individual for prescription drugs would be subject to the 5 percent aggregate cap (described on page 2) as applied on a monthly or quarterly basis.

Physician Overrides
Cost sharing must be limited to the levels applicable to a preferred drug when the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual as a non-preferred drug, would have adverse effects for the individual, or both. The State is responsible for developing and establishing the necessary process to implement this provision. These overrides must meet the State criteria for prior authorization and be approved through that process before preferred drug cost sharing can be applied to the non-preferred drug.

Enforcement
In accordance with section 1916A(d), States may permit pharmacy providers to require the receipt of the cost sharing payment from the beneficiary before filling a prescription.

Effect on Providers
State payments to providers must be reduced by the amount of the beneficiary cost-sharing obligations, regardless of whether the provider successfully collects the cost-sharing. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

Availability of Information
States should make available to the public and to beneficiaries the schedule of the cost-sharing/premium amounts for specific items and the various eligibility groups, (including pharmacy, if the State elects to impose differential cost sharing for preferred and non-preferred drugs).

Effective Date
This provision became effective March 31, 2006. States must submit a SPA to implement cost sharing. We have attached a SPA template for your convenience. SPA submissions should be submitted electronically in a "pdf" file format.

State Plan Preprints
States may use the attached State plan preprint pages to adopt any of these provisions. Please submit your SPA electronically in a "pdf" file format to your regional office to implement these provisions. It should be noted that States using a prior authorization program for preferred drug lists without tiered cost sharing are not required to change their programs to comply with this provision.

The Centers for Medicare & Medicaid Services contact for this new legislation is Jean Sheil, Director, Family and Children's Health Program Group, who may be reached at 410-786-5647.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:

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