DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106-2898

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

June 22, 2020

Donna Frescatore
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, Suite 1211
Albany, NY 12210

RE: Approval of New York State Plan Amendment Transmittal Number 15-0011

Dear Ms. Frescatore:

This is to notify you that New York State Plan Amendment (SPA) Transmittal Number 15-0011, has been approved on June 9, 2020, for adoption into the State Medicaid Plan with an effective date of October 1, 2015. This SPA adds additional exempt groups from Medicaid copays.

As discussed with the State, a companion letter has been issued with the approval of this SPA to memorialize a short term mitigation strategy that the State will implement until the State is able to come into full compliance with statute and regulation related to tracking cost sharing and premiums.

Enclosed are copies of the approved SPA #15-0011.

If you have any questions or wish to discuss this SPA further, please contact Ms. Maria Tabakov at (212) 616-2503.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Donna Frescatore
Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
One Commerce Plaza, Suite 1211
Albany, NY 12210

Dear Ms. Frescatore:

This letter is being sent as a companion to the approval of New York State Plan Amendment (SPA) #15-0011. This letter memorializes a short term mitigation strategy that the state will implement until the state is able to come into full compliance with statute and regulation related to tracking cost sharing and premiums.

Sections 1916A(a)(2)(B), 1916A(b)(1)(B)(ii), and 1916A(b)(2)(A) of the Social Security Act, as implemented at 42 CFR §447.56(f), require the state to limit the amount of out-of-pocket expenditures that a beneficiary may incur. The state may not impose premiums and/or cost sharing that exceed an amount of 5 percent of family income (aggregate cap), on either a monthly or quarterly basis. The state's current practice is to set an annual cap of $200 for all non-exempt beneficiaries with income over 100 percent of the federal poverty level (FPL). While states have flexibility to limit cost sharing below a person's calculated 5 percent aggregate cap, in this instance, the state's cap could still result in some individuals exceeding their 5 percent aggregate cap. Lastly, the state's policy to track annually, rather than monthly or quarterly is inconsistent with our rules.

During our review of SPA #15-0011, the state informed CMS that it would comply with the aggregate cap and its associated tracking requirements by taking the following two steps: 1) setting a quarterly cap at $50 for beneficiaries with income over 100 percent of the FPL, which would result in all individuals subject to cost sharing charges never exceeding his/her aggregate cap, and 2) making systems changes to allow the state to track cost sharing and then turn off cost sharing once a beneficiary has reached his/her cap for the quarter. The state expects to fully implement an automated tracking system by April 1, 2021.

As the state works toward the tracking system implementation date, the state has delegated, as an interim step, responsibility to track to its managed care entities. As of April 1, 2020, managed care entities have begun to track copays incurred by enrollees not otherwise exempt from cost sharing. The state has developed processes to identify these individuals for the managed care entities and provide oversight of those managed care entities. The managed care entities will track the copays and inform beneficiaries when they have reached their respective caps. Given that the vast majority of Medicaid beneficiaries in the state are enrolled in managed care, this new requirement will greatly reduce the number of individuals who could exceed their respective caps.

If you have any questions about this letter or require any further assistance, please contact Maria Tabakov at (212) 616-2503, or Maria.Tabakov@cms.hhs.gov.

Sincerely,

[redacted]

Division of Program Operations

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **New York**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

TN-15-0011

Proposed Effective Date

10/01/2015 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Â§1902(a) of the Socia l Security Act, and 42 CFR 447

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 1075.00
Second Year	2016	$ 1075.00

Subject of Amendment

New Populations/groups exempt from Medicaid cost sharing (co-pays).

Governor's Office Review

- (●) **Governor's office reported no comment**
- ( ) **Comments of Governor's office received**

  Describe:

- ( ) **No reply received within 45 days of submittal**
- ( ) **Other, as specified**

  Describe:

Signature of State Agency Official

Submitted By:	**Michelle Levesque**
Last Revision Date:	**May 19, 2020**
Submit Date:	**May 19, 2020**

Medicaid Premiums and Cost Sharing

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: TN - 15 - 0011

Cost Sharing Requirements G1

1916
1916A
42 CFR 447.50 through 447.57 (excluding 447.55)

The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid. Yes

☑ The state assures that it administers cost sharing in accordance with sections 1916 and 1916A of the Social Security Act and 42 CFR 447.50 through 447.57.

General Provisions

☑ The cost sharing amounts established by the state for services are always less than the amount the agency pays for the service.

■ No provider may deny services to an eligible individual on account of the individual's inability to pay cost sharing, except as elected by the state in accordance with 42 CFR 447.52(e)(1).

■ The process used by the state to inform providers whether cost sharing for a specific item or service may be imposed on a beneficiary and whether the provider may require the beneficiary to pay the cost sharing charge, as a condition for receiving the item or service, is (check all that apply):

☐ The state includes an indicator in the Medicaid Management Information System (MMIS)

☐ The state includes an indicator in the Eligibility and Enrollment System

☒ The state includes an indicator in the Eligibility Verification System

☐ The state includes an indicator on the Medicaid card, which the beneficiary presents to the provider

☐ Other process

■ Contracts with managed care organizations (MCOs) provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in 42 CFR 447.50 through 447.57.

Cost Sharing for Non-Emergency Services Provided in a Hospital Emergency Department

The state imposes cost sharing for non-emergency services provided in a hospital emergency department. Yes

☑ The state ensures that before providing non-emergency services and imposing cost sharing for such services, that the hospitals providing care:

■ Conduct an appropriate medical screening under 42 CFR 489.24, subpart G to determine that the individual does not need emergency services;

■ Inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department;

■ Provide the individual with the name and location of an available and accessible alternative non-emergency services provider;

- ■ Determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and
- ■ Provide a referral to coordinate scheduling for treatment by the alternative provider.

☑ The state assures that it has a process in place to identify hospital emergency department services as non-emergency for purposes of imposing cost sharing. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by any managed care organization.

The process for identifying emergency department services as non-emergency for purposes of imposing cost sharing is:

The Emergency Department medical professionals make a determination as to whether the services provided were non-emergency or not. When determined to be non-emergency, the claim for services would be submitted with the 'non-emergency' indicator, and the system will remove the copay amount from the reimbursement amount. In NYS the $3 copay for non-emergent use of the emergency department is equal to the $3 copay for clinic services. Services are never denied due to the inability or failure to pay a co-payment. NYS has current initiatives (Delivery System Reform Incentive Payment / Health Homes) underway to decrease potentially preventable emergency department visits. Members who present to the ER with a non-emergent condition will incur the same $3 copay if they are treated in the ER or are referred to the facility's outpatient clinic for care.

Cost Sharing for Drugs

The state charges cost sharing for drugs.	Yes
The state has established differential cost sharing for preferred and non-preferred drugs.	No

■ All drugs will be considered preferred drugs.

Beneficiary and Public Notice Requirements

☑ Consistent with 42 CFR 447.57, the state makes available a public schedule describing current cost sharing requirements in a manner that ensures that affected applicants, beneficiaries and providers are likely to have access to the notice. Prior to submitting a SPA which establishes or substantially modifies existing cost sharing amounts or policies, the state provides the public with advance notice of the SPA, specifying the amount of cost sharing and who is subject to the charges, and provides reasonable opportunity for stakeholder comment. Documentation demonstrating that the notice requirements have been met are submitted with the SPA. The state also provides opportunity for additional public notice if cost sharing is substantially modified during the SPA approval process.

Other Relevant Information

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.

V.20160722

Medicaid Premiums and Cost Sharing

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: TN - 15 - 0011

Cost Sharing Amounts - Categorically Needy Individuals G2a

1916
1916A
42 CFR 447.52 through 54

The state charges cost sharing to all categorically needy (Mandatory Coverage and Options for Coverage) individuals. Yes

Services or Items with the Same Cost Sharing Amount for All Incomes

Add	Service or Item	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	FDA approved drugs to treat tuberculosis	0.00	$	Prescription		Remove
Add	FDA approved psychotropic drugs	0.00	$	Prescription		Remove

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Pharmacy Prescription Brand Name Drugs — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		3.00	$	Prescription		Remove

Service or Item: Pharmacy Prescription Generic, Preferred Brand, and Brand Less Than Generic Drugs — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		1.00	$	Prescription	When brand drug cost after consideration of all rebates is less than the generic equivalent, the brand is dispensed. Cost Sharing Amount is limited to the generic Cost Sharing Amount, holding member harmless.	Remove

Service or Item: Pharmacy Non-Prescription Drugs — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		0.50	$	Prescription		Remove

Service or Item: Clinic Visits — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		3.00	$	Visit		Remove

Service or Item: Laboratory Tests — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		0.50	$	Procedure		Remove

Service or Item: Medical Supplies — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		1.00	$	Item		Remove

Service or Item: Inpatient Hospital Stays (involving at least one overnight stay; is due upon discharge) — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		25.00	$	Entire Stay		Remove

Service or Item: Emergency Room - for non-urgent or non-emergency services — Remove Service or Item

Indicate the income ranges by which the cost sharing amount for this service or item varies.

Add	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	Remove
Add	100% FPL		3.00	$	Visit		Remove

Add Service or Item

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

If the state charges cost sharing for non-preferred drugs (entered above), answer the following question:

The state charges cost sharing for non-preferred drugs to otherwise exempt individuals. No

Cost Sharing for Non-emergency Services Provided in the Hospital Emergency Department Charged to Otherwise Exempt Individuals

If the state charges cost sharing for non-emergency services provided in the hospital emergency department (entered above), answer the following question:

The state charges cost sharing for non-emergency services provided in the hospital emergency department to otherwise exempt individuals.	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.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: TN - 15 - 0011

Cost Sharing Amounts - Medically Needy Individuals	G2b
1916 1916A 42 CFR 447.52 through 54	
The state charges cost sharing to all medically needy individuals.	Yes
The cost sharing charged to medically needy individuals is the same as that charged to categorically needy individuals.	Yes

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.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: TN - 15 - 0011

Cost Sharing Amounts - Targeting	G2c
1916 1916A 42 CFR 447.52 through 54	
The state targets cost sharing to a specific group or groups of individuals.	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.

V.20181119

Medicaid Premiums and Cost Sharing

State Name: New York

OMB Control Number: 0938-1148

Transmittal Number: TN - 15 - 0011

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).

Medicaid Premiums and Cost Sharing

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

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

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 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:
- [ ] 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:

Providers are informed by the Medicaid Eligibility Verification System (MEVS) when a beneficiary has no co-pay or if the beneficiary's co-pay limit has been met. Beneficiaries are also sent a system-generated letter when their co-pay limit has been met. Beneficiaries whose income is less than 100% of the FPL are not subject to cost-sharing. Beneficiaries whose income is greater than 100% of the FPL will not exceed a $50 quarterly co-pay maximum, which will ensure that beneficiaries will not incur cost sharing that exceeds the 5% aggregate quarterly limit as described in 42 CFR 447.56(f). Both fee-for-service and managed care populations will be tracked.

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:

Any disagreement with the Medicaid decision including co-pay can be challenged by the beneficiary through established fair-hearing process. Information about fair-hearing is provided on every notice that the beneficiaries receive and on the department website.

☑ 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:

Once the beneficiary reaches the limit or has met the maximum co-pay limit the system will indicate that to the provider who should not charge any co-pay. Co-pays are deducted from the payment to the providers and the provider collects co-pay from the beneficiary. In case of over-payment the provider returns the copay 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:

Beneficiaries are required to report any changes in income or the household. Any such change results in recalculation of the family budget and co-pay if applicable. No one is terminated and no service is denied for the beneficiary's inability to make a co-pay.

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

PRA Disclosure Statement

V.20160722

New York
54

Reserved

[Citation
42 CFR 447.51
through 447.55

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54

1916(a) and
of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under –

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.]

New York
55

Reserved

[Citation **4.18 (b)(2) (Continued)**

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.]

New York
56

Reserved

[Citation **4.18 (b) (Continued)**

42 CFR 447.51 through 447.46

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b)(3) above.

[ ] Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

[ ] 18 or older

[ ] 19 or older

[ ] 20 or older

[X] 21 or older

[ ] Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.]

New York
56a

Reserved

[Citation **4.18(b)(3) (Continued)**

42 CFR 447.51 through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

[ ] Not applicable. There is no maximum.]

New York
56b

Reserved

[Citation		
1902(c) of the Act	4.18(b)(4) [ ]	A monthly premium is imposed on pregnant women and infants who are covered under section 1902(a)(10)(A)(ii)(IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902(a)(52) and 1925(b) of the Act	4.18(b)(5) [ ]	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b)(4) and (5) of the Act.
1916(d) of the Act	4.18(b)(6) [ ]	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902(a)(10)(E)(ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916(d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.]

New York
56c

Reserved

[Citation

4.18(c) [X] Individuals are covered as medically needy under the plan.

42 CFR 447.51 through 447.58

(1) [ ] An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52(b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under –

[ ] Age 19

[ ] Age 20

[X] Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:]

New York
56d

Reserved

[Citation **4.18(c)(2) (Continued)**

42 CFR 447.51 through 447.58

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

[ ] Not applicable. No such charges are imposed.]

New York
56e

Reserved

[Citation **4.18(c)(3)** Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b)(2) above.

[ ] Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

[ ] 18 or older

[ ] 19 or older

[ ] 20 or older

[X] 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.]

New York
56f

Reserved

[Citation **4.18(c)(3) (Continued)**

447.51 through
447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

[ ] Not applicable. There is no maximum.]

New York
1

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)			X	$25 per recipient stay regardless of length of stay, payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost $50 or less. Therefore, the State will meet the requirements of 42 CFR 447.54(c)

]

New York
1a

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and
(7) of the Act:

Service	Type Charge Deduct. Copay.	Coins.		Amount and Basis for Determination
Ambulatory Services as follows:				The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims in accordance with 42 CFR 447.54 (a)(3)

]

New York
1b

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and
(7) of the Act:

Service	Type Charge			Amount and Basis for Determination
	Deduct. Copay.		Coins.	
Outpatient Hospital – including non-emergency or non-urgent medical services			X	$3
Diagnostic and Treatment Center (Free-standing clinics)			X	$3
X-Ray			X	$1 each procedure
Laboratory			X	$.50 each procedure
Medical/Sick Room Supplies			X	$1 each order

]

New York
1c

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
The following charges are imposed on the categorically needy for services:

SERVICE	TYPE OF CHARGE DEDUCTIBLE	COINSURANCE	CO-PAY	AMOUNT AND BASIS FOR DETERMINATION
Pharmacy				
1. Brand- name drugs			X	$3.00
2. Generic drugs			X	$1.00
3. Non-prescription drugs			X	$0.50
4. Preferred brand name drugs and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent			X	$1.00

]

New York
2

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for categorically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient's own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.]

New York
3

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

From November 1, 1993 through March 31, 1994, a cumulative maximum of $41 per Medicaid recipient will apply.

Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of $100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of $200 per Medicaid recipient will apply.]

New York
1

Reserved

[

1.) Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.

2.) Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.

3.) Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.

4.) Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.

5.) Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of "Family Planning Products." Family planning items are also identified in the MMIS during claims processing.]

New York
2

Reserved

[

6.) Services provided by an HMO to an enrollee are identified by the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.
Individuals enrolled in health maintenance organizations (HMO's) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the-counter medication ordered by a recognized practitioner as listed on Attachment 4.18-A, Page 1c.

7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

8.) Additional exclusions from co-payment may be made pursuant to state statute.]

New York
1

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct. Copay.		Coins.	Amount and Basis for Determination
Inpatient Hospital (defined here as article 28 and dually certified article 28 and 31 hospitals and out-of-state hospitals)			X	$25 per recipient stay regardless of length of stay, payable at discharge. In no event is it expected that an inpatient hospital stay of one day would cost less than $50. Therefore, the State will meet the requirements of 42 CFR 447.54(c)

]

New York
1a

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct. Copay.	Coins.		Amount and Basis for Determination
Ambulatory Services as follows:				The basis for determination of co-payments for the following services was calculated by finding the average or typical dollar amount for a particular service. It was calculated by selecting a fixed period of time and dividing the identified total dollar value of the service by the number of claims in accordance with 42 CFR 447.54 (a)(3)

]

New York
1b

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services:

Service	Type Charge Deduct. Copay.	Coins.		Amount and Basis for Determination
Outpatient Hospital – including non-emergency or non-urgent medical services			X	$3
Diagnostic and Treatment Center (Free-standing clinics)			X	$3
X-Ray			X	$1 each procedure
Laboratory			X	$.50 each procedure
Medical/Sick Room Supplies			X	$1 each order

]

New York
1c

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

The following charges are imposed on the medically needy for services other than those provided under Section 1916 of the Act:

SERVICE	TYPE OF CHARGE DEDUCTIBLE	COINSURANCE	CO-PAY	AMOUNT AND BASIS FOR DETERMINATION
Pharmacy				
1. Brand- name drugs			X	$3.00
2. Generic drugs			X	$1.00
3. Non-prescription drugs			X	$0.50
4. Preferred brand name drugs and brand name drugs, when cost after consideration of all rebates, is less than the generic equivalent			X	$1.00

]

New York
2

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

B. The method used to collect cost sharing charges for Medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The recipient's own declaration that he/she is unable to pay is the basis for determining when an individual is unable to pay.]

New York
3

Reserved

[STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

D. The procedures for implementing and enforcing the exclusions [form] from cost-sharing contained in 42 CFR 447.53(b) are described below:

Informational notices and letters have been sent to providers, recipients and local social service districts.

MMIS Systems have been implemented to exclude certain groups of recipients from co-pay requirements as follows: SEE SUPPLEMENT 1.

E. CUMULATIVE MAXIMUMS ON CHARGES:

☐ State policy does not provide for cumulative maximums.

☒ Cumulative maximums have been established as described below:

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Beginning April 1, 1994 through March 31, 1995 and each following year beginning on April first a cumulative maximum of $100 per Medicaid recipient will apply.

Beginning August 1, 2005 through March 31, 2006 and each following year beginning on April first, a cumulative maximum of $200 per Medicaid recipient will apply.]

New York
1

Reserved

[
1.) Children under age 21 are excluded based on a check of date of birth on the recipient file used during claim processing. The date of birth is printed on the plastic common benefit card.

2.) Pregnant women are excluded when requesting a service requiring copay. If not visibly apparent, a pregnant recipient can be determined by the type of drug or supply ordered, through a note signed by a physician which identifies the recipient as pregnant or through some other evidence which includes telephone contact with a physician or when the prescription source is a Prenatal Care Assistance Program (PCAP) or an obstetrician. The provider must indicate pregnancy on the claim form.

3.) Institutionalized individuals are identified and exempted during claims processing. These recipients usually do not leave the facility where they are institutionalized. When recipients require outside services, the facility makes arrangements and verifies the recipient exemption from copay.

4.) Emergency services are excluded by the providers indicating that the service is an emergency on the claim form.

5.) Family planning drugs and supplies are excluded from copay and are currently identified in the Provider Manuals under the headings of "Family Planning Products." Family planning items are also identified in the MMIS during claims processing.]

New York
2

Reserved

[

6.) Services provided by an HMO to an enrollee are identified [via] by the Electronic Medicaid Eligibility Verification System (EMEVS) to the provider of service. During claims processing, HMO enrollees and the services included in the capitation payment are identified as excluded.

Individuals enrolled in health maintenance organizations (HMO's) or other entities which provide comprehensive health services, or other managed care programs for services covered by such programs are exempt from co-payments, except that such persons shall be subject to co-payments for each generic prescription drug dispensed, each brand-name prescription drug dispensed, and each over-the counter medication ordered by a recognized practitioner.

7.) No service provided by a hospice is subject to co-pay. Services provided to individuals receiving hospice care are identified during MMIS claims processing and are exempted from co-pay requirements.

8.) Additional exclusions from co-payment may be made pursuant to state statute.]