# Table of Contents

**State/Territory Name: MN**

**State Plan Amendment (SPA) #: 15-0013**

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

February 11, 2016

Marie Zimmerman, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Ms. Zimmerman:

This letter serves to revise CMS' approval letter dated December 23, 2015 for the following State Plan Amendment:

Transmittal #15-0013 --Revisions to cost sharing premiums.
--Effective Date: July 1, 2015

This letter does not make any revisions to the content of the State Plan Amendment (SPA) pages or CMS Form 179 previously approved by CMS on December 23, 2015. However, at the time the SPA was approved, CMS did not provide superseding pages on the cover page of this SPA in our MMDL system. As such, this letter provides clarification on which pages this SPA supersedes.

The following pages of the Minnesota State Medicaid Plan will be superseded by G1, G2a, G2b, G2c, and G3 (Medicaid Premiums and Cost Sharing):

Section 4, Pages 54-56a, reserved
Section 4, Page 56c, delete paragraph (c)(2)
Section 4-56d-56f, reserved
Attachment 4.18-A, Pages 1-3 deleted
Attachment 4.18-C, Pages 1-3 deleted
Attachment 4.18-D, Pages 1-2, deleted

If you have any additional questions, please have a member of your staff contact Sandra Porter at (312) 353-8310 or via e-mail at Sandra.Porter@cms.hhs.gov.

Sincerely,

/s/
Ruth A. Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Ann Berg, MDHS
Sean Barrett, MDHS

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

- **State/Territory name:**

  **Minnesota**

- **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.**

  MN-15-0013

- **Proposed Effective Date**

  07/01/2015 *(mm/dd/yyyy)*

- **Federal Statute/Regulation Citation**

  Sections 1916

- **Federal Budget Impact**

| | Federal Fiscal Year | Amount |
|---|---|---|
| **First Year** | 2016 | $ 112000.00 |
| **Second Year** | 2017 | $ 112000.00 |

- **Subject of Amendment**

  This amendment revises Medica

- **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:**

    **Sean Barrett**

  - **Last Revision Date:**

    **Dec 18, 2015**

  - **Submit Date:**

    **Sep 24, 2015**

| **DATE RECEIVED:** | **DATE APPROVED:** |
|---|---|
| September 24, 2015 | December 23, 2015 |
| PLAN APPROVED – ONE COPY ATTACHED | |
| **EFFECTIVE DATE OF APPROVED MATERIAL:** | **SIGNATURE OF REGIONAL OFFICIAL:** |
| July 1, 2015 | /s/ |
| **TYPED NAME** | **TITLE** |
| Todd McMillion | Acting Associate Regional Administrator |

# Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

## 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

Description:

The Department issues bulletins and provider updates as cost-sharing requirements change. The Department also describes in its provider manual, all services and recipients subject to cost-sharing

■ 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:

Hospital emergency departments are informed that the copay applies to non-emergency services received, when the above conditions regarding screening, counseling and referral are met. An emergency is defined as a medical condition that manifests with acute symptoms (including severe pain) that, without immediate medical attention, could seriously jeopardize the physical or mental health of the individual or, with a pregnant woman, the health of the woman or unborn child. Hospitals have access to the Department's online provider directory in order to facilitate referrals.

**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. | Yes |

- ■ The state identifies which drugs are considered to be non-preferred.
- ☑ The state assures that it has a timely process in place to limit cost sharing to the amount imposed for a preferred drug in the case of a non-preferred drug within a therapeutically equivalent or similar class of drugs, if the individual's prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases, reimbursement to the pharmacy is based on the appropriate cost sharing amount.

**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.20140415

# Medicaid Premiums and Cost Sharing

State Name: Minnesota

Transmittal Number: MN - 15 - 0013

OMB Control Number: 0938-1148

Expiration date: 10/31/2014

## 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**

| | Service or Item | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|
| + | Non-preventive office visit | 3.00 | $ | Visit | Charged per office visit that was not subject to the family deductible. No co-payment for an office visit for physical therapy, occupational therapy, speech therapy, or mental health services. Only one co-payment per day, per treating provider. | X |
| + | Non-emergency visit to a hospital-based emergency room | 3.50 | $ | Visit | Charged per visit that was not subject to the family deductible. Only one co-payment per day, per treating provider. | X |
| + | Family deductible | 2.85 | $ | Month | The deductible is applied to the first eligible service received each month. This amount shall be increased each year beginning January 1, 2016, by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher five cent increment. No deductible applies to services in which a co-pay was assessed or the following: chemical dependency treatment services, pharmacy services, dental services, chiropractic services, eyeglasses, hearing aids and oxygen. | X |
| + | Prescribed drugs: Non -preferred drugs (brand-name) | 3.00 | $ | Prescription | No co-payment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. | X |
| + | Prescription drugs: Preferred drugs (generic) | 1.00 | $ | Prescription | No co-payment for: 1) anti-psychotic drugs used for treatment of mental illness; or 2) contraceptives. | X |

**Services or Items with Cost Sharing Amounts that Vary by Income**

Service or Item:

Remove Service or Item

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

| | Incomes Greater than | Incomes Less than or Equal to | Amount | Dollars or Percentage | Unit | Explanation | |
|---|---|---|---|---|---|---|---|
| + | | | | | | | X |

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



V.20140415

# Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

| Cost Sharing Amounts - Medically Needy Individuals | G2b |
|---|---|
| 1916<br>1916A<br>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.20140415

# Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

| Cost Sharing Amounts - Targeting | G2c |
|---|---|
| 1916<br>1916A<br>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.20140415

# Medicaid Premiums and Cost Sharing

State Name: Minnesota

OMB Control Number: 0938-1148

Transmittal Number: MN - 15 - 0013

Expiration date: 10/31/2014

## 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

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

Through September 30, 2016, the Department exempts from cost sharing all American Indians. Beginning no later than October 1, 2016, the Department will exempt from cost sharing only those American 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, in accordance with 42 CFR 447.56(a)(1)(x).

■ 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):

The Department's provider manual includes information describing services and individuals exempt from cost-sharing.

**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:

As claims are submitted for dates of service within the family's current monthly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit using the state's MMIS system. Once the family reaches the aggregate limit, based on incurred cost sharing, no additional cost-sharing obligations are incurred until the next month. Providers receive information regarding the recipient's cost-sharing as they verify eligibility through the eligibility verification system. At initial enrollment, recipients receive information related to cost-sharing and may contact the member services help-desk with additional questions, including the status of their monthly cost-sharing limit.
Recipients with household income exceeding 100% FPL are not expected to be at risk of reaching the aggregate family limit. Through December 31, 2016, such recipients must manually track their cost sharing charges and contact the recipient help desk to request a refund of excess cost sharing payments. This process is fully described on the Department's website. Beginning no later than January 1, 2017, the Department will track cost sharing for these recipients and notify them once they reach their monthly cost sharing limit.

[■] 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 family reaches the aggregate limit, based on incurred cost sharing, no additional cost-sharing obligations are incurred until the next month. Providers receive information regarding the recipient's cost-sharing as they verify eligibility through the eligibility verification system. At initial enrollment, recipients receive information related to cost-sharing and may contact the member services help-desk with additional questions, including the status of their

monthly cost-sharing limit. Beginning no later than January 1, 2017, the Department will also notify recipients via mail that they have reached their monthly cost sharing limit. Recipients will have the option to receive the notice electronically once that feature is operable.

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:

All appeals follow the state's fair hearing process in accordance with 42 C.F.R. Part 431, Subpart E.

☑ 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:

Providers who charge cost-sharing in excess of the family's monthly limit must refund the overage to the recipient. If necessary, the MMIS system will re-process claims and reimburse the provider(s)the correct payment amount. The provider(s) then refunds to the recipient the amount of cost-sharing determined to exceed the aggregate limit for the month.

☑ 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:

Reported changes in circumstance are applied through the state's eligibility system. Any changes that affect the recipient's aggregate cost-sharing limit are applied automatically.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). Yes

Description of additional aggregate limits:

The state limits cumulative prescription drug charges to $12 per person per month.

## PRA Disclosure Statement