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State Name: West Virginia

State Plan Amendment (SPA) #: 14-0007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
150 S. Independence Mall West
Suite 216, The Public Ledger Building
Philadelphia, Pennsylvania 19106-3499

CENTERS FOR MEDICARE & MEDICAID SERVICES

Region III/Division of Medicaid and Children's Health Operations

SWIFT #040220144079

SEP 18 2015

Cynthia Beane, MSW, LCSW
Acting Commissioner
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3706

Dear Acting Commissioner Beane:

The Centers for Medicare & Medicaid Services (CMS) would like to inform you of the approval of West Virginia's State Plan Amendment (SPA) 14-0007 entitled Medicaid Cost Sharing. This SPA proposes to amend the cost sharing obligations for West Virginia Medicaid beneficiaries.

The effective date of this amendment is January 1, 2014. Enclosed are the approved State Plan pages and a copy of the CMS Summary Page (CMS-179 form). Based on our conversation with Sarah Young, the PDFs approved in this SPA replaced the following State Plan pages:

Section 4, Pages 54-56a, reserved

Section 4, Page 56c, delete paragraph (c)(2)

Section 4, Page 56d-56f, reserved

Attachment 4.18-A, Pages 1-6 deleted

Attachment 4.18-C, Pages 1-6 deleted

If you have any questions about this SPA, please contact Margaret Kosherzenko of my staff at 215-861-4288.

Sincerely,

/S/

Francis McCullough
Associate Regional Administrator

Enclosures

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

State/Territory name: West Virginia

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.

WV-14-0007

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Cost Sharing

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:	**Sarah Young**
Last Revision Date:	**Sep 11, 2015**
Submit Date:	**Feb 12, 2015**

/S/

Francis McCullough
Associate Regional Administrator

Medicaid Premiums and Cost Sharing

State Name: West Virginia

Transmittal Number: wv - 14 - 0007

OMB Control Number: 0938-1148

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

☒ 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:

Hospitals will provide an appropriate medical screening evaluation on the individual to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations. If it is determined that it is not a condition that requires emergency treatment, the hospital will assist the recipient in locating a non-emergency services provider including determining whether the alternative provider can provide services to the individual in a timely manner. If the recipient decides to be treated at the emergency department for the non-emergency condition they will be informed at that time of the co-payment they will be charged.

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.20140415

Medicaid Premiums and Cost Sharing

State Name: West Virginia

OMB Control Number: 0938-1148

Transmittal Number: WV - 14 - 0007

Expiration date: 10/31/2014

Cost Sharing Amounts - Categorically Needy Individuals 42a

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	
+	Prescribed drugs	0.50	$	Prescription	If the State's payment is $5.01 to $10.00 the Co-pay is $.50	X
+	Prescribed drugs	1.00	$	Prescription	If the State's payment is $10.01 to $25.00 the Co-pay is $1.00	X
+	Prescribed drugs	2.00	$	Prescription	If the State's payment is $25.01 to $50.00 the Co-pay is $2.00	X
+	Prescribed drugs	3.00	$	Prescription	If the State's payment is $50.01 and above the Co-pay is $3.00	X
+	Non-Emergency Use of Emergency Department - Hospital Only	8.00	$	Visit	If after an appropriate medical evaluation it is determined that it is not a condition that requires emergency treatment and the member still opts to be treated at the ER, the member will be required to pay the $8 co-pay.	X

Services or Items with Cost Sharing Amounts that Vary by Income

Service or Item: Inpatient Hospital (Acute Care) 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	
+	0.00% of FPL	50.00% of FPL	0.00	$	Entire Stay	$0.00 per admission. WV will reduce a provider's reimbursement by $0.00.	X
+	50.01% of FPL	100.00% of FPL	35.00	$	Entire Stay	$35.00 per admission. WV will reduce a provider's reimbursement by $35.00.	X

Service or Item: Office Visit 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	
+	0.00% of FPL	50.00% of FPL	0.00	$	Visit	For providers of CPT Codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, and 99215 WV will reduce a provider's reimbursement by $0.00.	X

	Incomes Greater than	Incomes Less than or Equal to	Amount	Dollars or Percentage	Unit	Explanation	
+	50.01 of FPL	100.00% of FPL	2.00	$	Visit	For providers of CPT Codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, and 99215 WV will reduce a provider's reimbursement by $2.00.	X

Service or Item: Any outpatient surgical services excluding emergency rooms

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	
+	0.00% of FPL	50.00% of FPL	0.00	$	Other	Any outpatient surgical services rendered in a physician's office, Ambulatory Surgical Center or Outpatient Hospital excluding emergency services, WV will reduce a provider's reimbursement by $0.00	X
+	50.01% of FPL	100.00% of FPL	2.00	$	Other	Any outpatient surgical services rendered in a physician's office, Ambulatory Surgical Center or Outpatient Hospital excluding emergency services, WV will reduce a provider's reimbursement by $2.00	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

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: West Virginia

OMB Control Number: 0938-1148

Transmittal Number: 14 - __ - 0007

Expiration date: 10/31/2014

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.20140415

Medicaid Premiums and Cost Sharing

State Name: West Virginia

OMB Control Number: 0938-1148

Transmittal Number: WV - 14 - 0007

Expiration date: 10/31/2014

Cost Sharing Amounts - Targeting — C2c

1916
1916A
42 CFR 447.52 through 54

The state targets cost sharing to a specific group or groups of individuals. **Yes**

Population Name (optional):

Eligibility Group(s) Included: Adult Expansion Group (100.01-133% FPL); Transitional Medicaid (Phase I 100.01-No Limit FPL) (Phase II 100.01-185% FPL); Extended Medicaid (100.01-No Limit FPL); Former WV Foster Children (100.01-No Limit FPL); Working disabled individuals (M-WIN)(100.01-250% FPL); Medically Needy (spenddown) for aged, blind and disabled (SSI-Related)(100.01-No Limit FPL); Medically Needy (spenddown) for specified relatives (AFDC-Related)(100.01-No Limit FPL)

Incomes Greater than 100.01% FPL TO Incomes Less than or Equal to

	Service	Amount	Dollars or Percentage	Unit	Explanation	
+	Non-Emergency Use of Emergency Department - Hospital Only	8.00	$	Visit	If after an appropriate medical evaluation it is determined that it is not a condition that requires emergency treatment and the member still opts to be treated at the ER, the member will be required to pay the $8 co-pay.	X
+	Inpatient Hospital (Acute Care)	75.00	$	Entire Stay	$75.00 per admission. WV will reduce a provider's reimbursement by $75.00. The average inpatient cost for SFY is $5,042.00	X
+	Office Visit	4.00	$	Visit	For providers of CPT Codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, and 99215 WV will reduce a provider's reimbursement by $4.00. The average office visit reimbursement is $52.22.	X
+	Any outpatient surgical services excluding emergency room	4.00	$	Visit	Any outpatient surgical services rendered in a physician's office, Ambulatory Surgical Center or Outpatient Hospital excluding emergency services, WV will reduce a provider's reimbursement by $4.00	X

The state permits providers to require individuals to pay cost sharing as a condition for receiving items or services, subject to the conditions specified at 42 CFR 447.52(e)(1). This is only permitted for non-exempt individuals with family income above 100% FPL. **Yes**

Providers may require payment of cost sharing as a condition for receiving all items or services listed above. **Yes**

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

If the state targets cost sharing for non-preferred drugs to specific groups of individuals (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 to specific individuals (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

Remove Population

Add Population

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: West Virginia

OMB Control Number: 0938-1148

Transmittal Number: 14 - - 0007

Expiration date: 10/31/2014

Cost Sharing Limitations — CS

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. — No

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 specifically 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):

The state utilizes the single streamlined application for self-attestation purposes.

☒ 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:

As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the Managed Care Organization 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 Managed Care Organization 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.

☐ 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:

On a monthly basis, the MMIS system will automatically generate a co-pay (cost sharing) letter for those beneficiaries who have reached the quarterly aggregate limit/cap during that month. This letter will only be generated when the family has met their cap/aggregate limit for the quarter. The letter will have the head of household, members of the case, and claim details for the month being reported for each individuals member in the household. Also, the letter will include the total co-pays for each household member with medical and pharmacy co-pays separated.

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:

W.Va. Code Section 9-2-6(13)(14) allows a beneficiary to request an appeal pertaining to public assistance. If a

beneficiary was charged a co-pay and, in fact, reimbursed a provider for that co-pay the member may request an appeal that the co-pay was improperly applied to them.

☒ 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:

If a member was inappropriately charged a co-pay and reimbursed a provider that co-pay, BMS will notify the provider of the miscalculation, reimburse the provider the difference in payment amount and request the provider to reimburse the member.

If a member was inappropriately charged a co-pay and did not reimburse a provider the amount, BMS will notify the provider of the miscalculation and reimburse the provider the difference in payment amount.

☒ 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:

When the family reports a change in circumstances, the eligibility system recalculates the applicable FPL% and passes this information to the claims system and member's file.

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

PRA Disclosure Statement

V.20140415