MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 15-49

Distribution: All Providers

Issued: December 1, 2015

Subject: Cost-Sharing Limits

Effective: January 1, 2016

Programs Affected: Medicaid, Health Michigan Plan

NOTE: Implementation of this policy is contingent upon State Plan Amendment Approval from the Centers for Medicare & Medicaid Services (CMS)

The Michigan Department of Health and Human Services (MDHHS) will be modifying system operations to ensure that cost-sharing limits for Medicaid beneficiaries are consistent with 42 CFR §447.56(f). This policy is effective January 1, 2016, subject to approval of a State Plan Amendment by CMS.

Cost-Sharing Limits

Medicaid cost-sharing, which includes premiums, copays, co-insurance and deductibles, incurred by individuals in a Medicaid household may not exceed an aggregate limit of 5% of family income. MDHHS will implement these limits on a calendar quarter basis through the tracking of claims for services as they are processed through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS). Through CHAMPS, MDHHS will track incurred costs and share relevant cost-sharing limit information with providers as explained further below. Providers are expected to utilize the information in CHAMPS to determine whether cost-sharing may be assessed at the time of the visit and inform the beneficiary of his or her cost-sharing obligations. Beneficiaries may not be charged cost-sharing in excess of the limit, and are not required to track cost-sharing charges. Beneficiaries who have questions can access cost-sharing information through the myHealth Button and myHealth Portal applications, as well as the Beneficiary Helpline.

Provider Responsibilities

Providers are currently directed to check beneficiary eligibility using CHAMPS at the time of every service. Beginning on October 1, 2015, the eligibility response within CHAMPS includes the following cost-sharing information:

- Cost-Share Met (Y or N);
- Cap Amount Remaining; and
- Copayment (for various services).

The eligibility response will only provide current calendar quarter cost-sharing information regardless of the date queried and will only provide information for a single date of service.

The following examples are provided to demonstrate the operation of the above eligibility information in CHAMPS:

Example #1

A beneficiary visits a physician office for an appointment. The provider checks eligibility in CHAMPS and sees the following information:

Cost-Share Met: N
Cap Amount Remaining ($): 75

Copayment Information
Professional (Physician) Visit - Office: $2

The provider may charge the beneficiary a copay for the visit, consistent with existing Medicaid policy.

Example #2

A beneficiary visits the hospital for a non-emergent admission. The provider checks eligibility in CHAMPS and sees the following information:

Cost-Share Met: N
Cap Amount Remaining ($): 20

Copayment Information
Hospital-Inpatient: $50

The provider may charge a copay for the visit, but may not charge the full amount permitted by policy. Specifically, the hospital provider may only charge $20, as a greater amount would lead to charges in excess of the limit. The provider is then expected to inform the beneficiary that cost-sharing has been met for the current calendar quarter.

Example #3

A beneficiary visits the dentist for an appointment. The provider checks eligibility in CHAMPS and sees the following information:

Cost-Share Met: Y
Cap Amount Remaining ($): 0

Copayment Information
Dental Care: $0

The provider may not charge a copay for this visit and is expected to inform the beneficiary that cost-sharing has been met for the current calendar quarter.

Beneficiaries who are exempt from cost-sharing per Medicaid policy (e.g. beneficiaries under 21, individuals receiving hospice care, etc.), will remain exempt. While the information in CHAMPS may reflect that the limit has not been met, the copay amount will continue to be shown as $0 because the beneficiary is exempt and may not be charged.

Pharmacy Impacts

For pharmacy providers, any remaining copay responsibility will be communicated in the National Council for Prescription Drug Programs (NCPDP) transaction response field 505-F5 (Patient Pay Amount). The Point of Sale (POS) system will determine whether the aggregate limit has been met.

Healthy Michigan Plan Impacts

Consistent with existing policy, Healthy Michigan Plan beneficiaries enrolled in a health plan are not responsible for co-pays at the point of service as long as the service is covered by the health plan. These co-pays will be collected through the MI Health Account, as applicable.

Services provided to Healthy Michigan Plan health plan enrollees that are not covered by the beneficiary's health plan may be subject to copays at the point of service, subject to existing policy requirements and the cost-sharing limitations described above.

Finally, Healthy Michigan Plan members not enrolled in managed care will be subject to co-pays at the point of service, subject to existing policy requirements and the cost-sharing limitations described above.

Modifications to cost-sharing limits consistent with PA 107 of 2013 or any Healthy Michigan Plan waiver amendment approved by CMS will be addressed through a future bulletin as appropriate.

Preventing Incurred Costs in Excess of Limits

Because CHAMPS will be tracking beneficiary costs-incurred as claims are adjudicated, providers are directed to bill all claims in a timely fashion. Providers are also directed to review the remittance advice to ensure that any copay charged at the time of service was appropriate. If any of the following Claim Adjustment Reason Codes (CARCs) are present, the provider is directed to refund any copay collected from the beneficiary for the service at issue, or cease pursuit of any copay not yet collected:

- 106
- 3 (with Reason Remark Codes N549 or N16)

Medicaid Health Plans that charge copays to Medicaid (i.e. MA-MC) beneficiaries will have administrative responsibilities to work with their providers to provide refunds when necessary or as directed by MDHHS.

Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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