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

**Centers for Medicaid and State Operations**

August 15, 2007 SMDL #07-010

Dear State Medicaid Director:

The purpose of this letter is to provide you with additional information about sections 6041, 6042, and 6043 of the Deficit Reduction Act (DRA) of 2005, Public Law No.109-171, and to provide guidance on changes enacted by the Tax Relief and Health Care Act (TRHC) of 2006, Public Law No.109-432**.** We are also providing specific guidance about Section 6043 of the DRA**,** "Emergency Room Co-payments for Non-Emergency Care." This provision added a new subsection 1916A(e) of the Social Security Act (the Act), which provides a State option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver, and also added a new subsection 1903(y) of the Act providing $50,000,000 in Federal grant funds over 4 years for States to use for the establishment of alternate non-emergency service providers, or networks of such providers.

The addition of sections 1916A(e) and 1903(y) of the Act provides new opportunities for States to work with the Federal Government to implement effective reforms to slow spending growth while maintaining needed coverage. These sections also will help people to get the kind of care they prefer in non-emergency settings. These provisions are effective as of January 1, 2007.

On June 16, 2006, we issued a State Medicaid Director's letter to provide guidance on the alternate cost-sharing provisions of DRA sections 6041 and 6042. The TRHC, enacted on December 20, 2006, made some technical changes to those provisions. Those changes are described below and are effective as if originally enacted in the DRA.

**Technical Changes to Sections 6041 and 6042 of the DRA Related to Individuals With Family Incomes At or Below 100 Percent of the Federal Poverty Level (FPL)**

The TRHC clarified that, in the case of individuals at or below 100 percent of the FPL, cost sharing for non-emergency services furnished in a hospital emergency room may be imposed as long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency room. Such cost sharing may not exceed nominal cost sharing levels, and is subject to the aggregate cost sharing cap of 5 percent of family income.

The cost sharing limitations under section 1916 shall continue to apply with the exception of cost sharing for pharmacy or non-emergency use of an emergency room which the State elects under section 1916A(c) or (e).
The amount, scope, and duration of benefit requirements of section 1902(a)(10)(B) shall continue to apply to cost sharing.
The enforceability provisions of section 1916A(d) do not apply.
The total aggregate cost sharing cap of 5 percent of family income (as determined by the State on a quarterly or monthly basis) would apply to the extent that cost sharing is permitted under sections 1916, 1916A(c) (pharmacy), and 1916A(e) (non-emergency use of the emergency room).

**Subsection 1916A(e) – Emergency Room Co-Payments for Non-emergency Services**

Section 1916A(e) of the Act allows States to amend their State plans to allow hospitals to impose cost sharing on an individual (within one or more groups of individuals specified by the State) who receives non-emergency care furnished in the hospital emergency department. In order for the hospital to impose cost sharing:

- The individual must actually have available and accessible an alternate non-emergency services provider with respect to the necessary services.

- The hospital must inform the beneficiary (after the beneficiary has received an appropriate medical screening examination under section 1867—the Emergency Medical Treatment and Active Labor Act, or EMTALA provision of the Act, and after a determination has been made that the individual does not have an emergency medical condition) before providing the non-emergency services that:
    - The hospital may require the payment of the State-specified cost sharing before the service can be provided;
    - The hospital provides the name and location of an alternate non-emergency services provider that is actually available and accessible;
    - An alternate provider can provide the services without the imposition of the State-specified higher cost sharing for the inappropriate use of the emergency room (nothing under this language should be construed as preventing a State from applying (or waiving) cost sharing otherwise permissible under section 1916A of the Act); and
    - The hospital provides a referral to coordinate scheduling of this treatment.

Under this provision, the term "non-emergency services" means care or services furnished in an emergency department of a hospital that do not constitute an appropriate medical screening examination, or stabilizing examination, and treatment required to be provided by the hospital under section 1867 of the Act.

Also, the term "alternative non-emergency services provider" means, with respect to non-emergency services for the diagnosis or treatment of a condition, a health care provider—such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider that:

- can provide clinically appropriate services for the diagnosis or treatment of a condition concurrently with the provision of the non-emergency services that would be provided in an emergency department of a hospital for the diagnosis or treatment of a condition; and
- is participating in the Medicaid program.

**Limitations Relating to Cost Sharing for Other Individuals**

*Individuals with Family Incomes between 100 and 150 percent of the FPL*

For an individual with a family income between 100 and 150 percent of the FPL, the co-payments imposed under section 1916A(e) may not exceed twice the amount determined to be nominal under

section 1916 of the Act. Such cost sharing is also subject to the aggregate cost sharing cap of 5 percent of family income under section 1916A(b)(2)(A).

*Individuals Exempt under Section 1916A of the Act*
In the case of an individual who is identified as otherwise exempt from alternative cost sharing under section 1916A(b)(3) of the Act, a State may impose emergency room co-payments for non-emergency care in an amount that does not exceed a nominal amount (as determined under section 1916) as long as no cost sharing would be imposed in order to receive the care through an outpatient department or other alternative non-emergency health care provider in the geographic area of the hospital emergency department involved. States may not impose cost-sharing on individuals receiving emergency services (as defined by the Secretary and consistent with current law outlined in Section 1916(a)(2)(D) of the Act) in an emergency room. Below is a list of exempt populations and services not subject to cost sharing under section 1916A(b)(3) of the Act:

- Individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals to whom child welfare services are made available under part B of title IV on the basis of being a child in foster care or individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age;
- Pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Any terminally ill individual who is receiving hospice care;
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs for medical care all but a minimal amount of the individual's income required for personal needs;
- Women who are receiving medical assistance by virtue of the application of breast or cervical cancer provisions;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Family planning services and supplies, and
- Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc). (This group was added by the TRHC).

*Application of Aggregate Cap and Relationship to Other Cost Sharing*
Cost sharing applied under this provision is subject to the 5 percent maximum aggregate cap for cost sharing as specified under 1916A of the Act, as applied on a monthly or quarterly basis (as specified by the State). This total aggregate cost sharing cap of 5 percent of family income applies to any cost-sharing amounts under sections 1916, 1916A(a), 1916A(c) (pharmacy), and 1916A(e) (non-emergency use of the emergency room).

If co-payments are imposed under this provision, no other co-payments or co-insurance may otherwise be imposed for the emergency room services under sections 1916A(a), 1916(a)(3), or 1916(b)(3) of the Act.

**EMTALA and Prudent Layperson Requirements**

Nothing in this provision limits a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act, or modifies any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization.

**State Plan Submission**

States may use the enclosed State plan preprint page (Enclosure A) to adopt cost sharing pursuant to this provision, States must include it in their approved State plan. For your convenience we have enclosed a template for a State plan amendment. Please submit your State plan amendment electronically in a "PDF" file format to your Centers for Medicare & Medicaid Services (CMS) regional office in order to implement this provision.

**Subsection 1903(y) – Grant Funds for Establishment of Alternate Non-emergency Services Providers**

Subsection 1903(y) of the Act authorizes the payment of $50,000,000 during the 4-year period beginning in 2007 in order to provide payment to States for the establishment of alternate non-emergency service providers or networks of providers. (See page 2 for the definition of an alternate non-emergency services provider.)

In providing for payments to States under subsection 1903(y) of the Act, the Secretary shall provide preference to States that establish, or provide for, alternate non-emergency services providers or networks of providers that:

- serve rural or underserved areas where Medicaid beneficiaries may not have regular access to providers of primary care services; or
- are in partnership with local community hospitals.

Additionally, in reviewing applications, CMS will consider as a special circumstance whether the grant funding is necessary to further the implementation of a pending or approved State plan amendment for section 1916A(e) of the Act for hospitals to impose cost sharing for non-emergency services provided in a hospital emergency department.

The Funding Opportunity Number is HHS-2007-CMS-ANESP-0005. To apply, go to http://www.grants.gov. You must "Get Registered" before you apply. On the left of the screen, select "Get Registered" and follow the directions. When that is completed, select "Apply for Grants" and follow the directions. Please do not wait until the application deadline date to begin the application process through the Web site http://www.grants.gov. We recommend you visit the Web site at least 30 days prior to filing your application to fully understand the process and requirements. Also, submit your application well in advance of the closing date in order to allow time to submit a hard copy by overnight mail if difficulties are encountered. For questions on the application process select "Contact Us" at the http://www.grants.govWeb site and you will be given the option to telephone or e-mail your questions to the support center.

We strongly encourage you to consider these grant opportunities to develop proposals to enhance your Medicaid program. The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children's Health Programs, who may be reached at (410) 786-5647. If you have any additional questions, please let us know.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators Division of
Medicaid and Children's Health

Martha Roherty Director, Health Policy Unit American Public Human Services Association Joy Wilson Director, Health Committee National Conference of State Legislatures

Matt Salo Director of Health Legislation National Governors Association

Jacalyn Bryan Carden Director of Policy and Programs Association of State and Territorial Health Officials

Christie Raniszweski Herrera Director, Health and Human Services Task Force American Legislative Exchange Council

Debra Miller Director for Health Policy Council of State Governments