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Division of Medicaid Services

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DMS Operations Memo 20-09

To: Income Maintenance Supervisors
Income Maintenance Lead Workers
Income Maintenance Staff

Affected Programs:
- ☒ BadgerCare Plus
- ☐ Caretaker Supplement
- ☐ FoodShare
- ☐ FoodShare Employment and Training
- ☒ Medicaid
- ☐ SeniorCare

From: Rebecca McAtee, Bureau Director
Bureau of Enrollment Policy and Systems
Division of Medicaid Services

Five Percent Cost Share Limit for Health Care Premiums and Copays

CROSS REFERENCE

- BadgerCare Plus Handbook, Section 38.2 List of Covered Services and Copayments and 51.1 BadgerCare Plus Categories
- Medicaid Eligibility Handbook, Section 21.5 Copayment
- 42 CFR 447.56
- Wis. Stat. §49.45(18)(ac)

EFFECTIVE DATE

July 1, 2020

PURPOSE

This operations memo announces the implementation of a federally mandated five percent cost share limit for health care premiums and copays for BadgerCare Plus, Medicaid for the Elderly Blind or Disabled (EBD Medicaid), and SSI Medicaid members. An automated process will track and enforce the five percent cost share limit. This memo also announces that certain member populations will no longer be charged copays for Medicaid or BadgerCare Plus-covered services.

BACKGROUND

Federal requirements do not permit states to charge Medicaid and Children's Health Insurance Program (CHIP) recipients more than five percent of their monthly income for out-of-pocket health care cost sharing expenses, defined as copays and premiums. While few members have cost sharing expenses that exceed that limit, states are required to have a system in place to guarantee that no member will have premium and copay expenses greater than five percent of their income. States are also required to:

- Notify members of the amount of their monthly cost share limit.

- Inform members of their right to appeal if they disagree with the amount of the limit.
- Notify members and inform health care providers when the cost share limit has been reached for a given month, to prevent members from incurring cost sharing expenses that exceed the limit.

Effective for the July 2020 benefit month, Wisconsin is implementing an automated process to track and enforce the five percent cost share limit as it relates to health care premiums and copays. Cost sharing limits will be set in CARES based on the household's income. A member's premium obligation will be subtracted from their copay limit to ensure that the member's total premiums and copay expenses do not exceed the five percent limit. The copay limit will then be tracked between CARES and ForwardHealth interChange. With the enhancements announced in this memo, Wisconsin will be in compliance with federal requirements for tracking cost share limits.

POLICY

Out-of-pocket cost sharing expenses for most health care programs are limited to five percent of household income. The five percent cost share policy applies to members eligible for SSI Medicaid, BadgerCare Plus, and EBD Medicaid, with exceptions noted below.

For the policy outlined in this memo, "cost share" refers to costs imposed on Medicaid services, including monthly premiums and copays for BadgerCare Plus and Medicaid card services. This policy does not refer to Medicaid deductibles, patient liability for Institutional Medicaid, or cost sharing for Home and Community Based Waiver services.

Certain subprograms are excluded from the five percent cost share limit, and certain member populations and subprograms are exempt from copays. These subprograms and populations are listed below.

SUBPROGRAMS EXCLUDED FROM THE FIVE PERCENT COST SHARE LIMIT

Members enrolled in the following subprograms will continue to be charged premiums and copays with no five percent cost share limit set based on their income:

- Medicaid Purchase Plan (MAPP)
- SeniorCare

Note: Members who are enrolled only in Medicare Savings Programs (except for Qualified Medicare Beneficiaries (QMB)) do not receive Medicaid card services and thus do not have copays.

MEMBER POPULATIONS AND SUBPROGRAMS EXEMPT FROM COPAYS

Effective July 1, 2020, copays will not be charged for the following member populations:

- All children under age 19, regardless of income level or health care program
- Children in adoption assistance, regardless of age
- Children in foster care, regardless of age
- Former Foster Care Youth
- Members receiving services through Express Enrollment
- People who are eligible to receive services from Indian Health Services or an Urban Indian Health Center, members of a federally recognized tribe, or the child or grandchild of a tribal member, regardless of age or income level

- Pregnant women

In addition, copays will not be charged for members enrolled in the following subprograms:
- Family Planning Only Services
- Institutional Medicaid (Note: This does not include childless adults (CLAs) enrolled in BadgerCare Plus and residing in an institution or MAPP members residing in an institution. These members may still be subject to copays.)
- Katie Beckett
- Medicaid and BadgerCare Plus Emergency Services Only
- Wisconsin Well Woman Medicaid

Note that most of these member populations and subprograms were already exempt from copays prior to July 1, 2020. However, prior to the temporary suspension of copays on January 1, 2020, some children enrolled in BadgerCare Plus and 18 year olds enrolled in Medicaid were subject to copays.

DETERMINING THE PER-MEMBER COPAY LIMIT

Cost sharing limits will be set in CARES based on the household's income. Premiums will be subtracted from copay limits to ensure that the total premiums and copay expenses for the household do not exceed the five percent limit. The copay limit will then be tracked between CARES and ForwardHealth interChange.

For health care assistance groups confirmed in CARES and SSI Medicaid, CARES will automatically determine copay limits and issue related member notices. For manual certifications, workers will be required to determine the member's correct copay limit per policy and enter it on the manual certification form and Notice of Decision. For manually certified and gap filling cases, whose certifications are sent to the EM CAPO, the copay limit must be provided as part of the certification. Detailed guidance will be in Process Help after May 30.

The information and examples provided in this memo explain how the per-member copay limits will be determined for various programs and program combinations, and in what situations copay limits will be prorated between spouses.

Per-member copay limits will be set based on the income tiers shown in the following table.

2020 Per-Member Copay Limits											
	Assistance Group Income Tier as Percentage of the Federal Poverty Level										
Status	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	$0	$26	$53	$79	$106	$132	$159	$186	$212	$239	$265
Prorated	$0	$13	$26.50	$39.50	$53	$66	$79.50	$93	$106	$119.50	$132.50

Note: Because the copay limits are based on income as a percentage of the federal poverty level (FPL), copay limits may be updated annually to reflect the new FPL amounts. Any updates to copay limits will be included in the annual operations memo that announces the new FPL amounts. The examples throughout this memo reflect the copay limit amounts for 2020.

COPAY LIMITS FOR BADGERCARE PLUS AND EBD MEDICAID MEMBERS

For members enrolled in BadgerCare Plus or EBD Medicaid subprograms that have a copay limit, copay limits will be based on the assistance group's income used to determine eligibility (except for Group B and B+ Home and Community Based Waiver members; see page 6).

The copay limit will be calculated for the assistance group as a whole. If the member is married and both spouses are enrolled in a health care program with a copay limit (and neither spouse is exempt from copays), the copay limit will be prorated between them.

Example 1: Jane and Benji are married with two children. The family is enrolled in BadgerCare Plus and is filing taxes jointly. Under tax filing rules, the assistance group has counted income of $2,000 per month, which puts their household income in the >50-100% of FPL income tier for an assistance group size of four.

$2,000 (assistance group income) / $2,183.33 (100% of the FPL for a group size of 4) = 0.916 = 91%

Since both parents are eligible and have to pay copays, the $26 copay limit for the household will be prorated between Jane and Benji. They will each have a per-member monthly copay limit of $13.

If one spouse is exempt from copays (for example, due to pregnancy), the other spouse will have the full individual copay limit for their income tier.

Example 2: Marianne, who is pregnant, and Joe are a married couple enrolled in BadgerCare Plus. Their income falls in the >50-100% of FPL income tier for a group size of three (because of the pregnancy). Marianne has a pregnancy due date of March 10. Marianne is exempt from copays beginning with the first month she is certified as a pregnant woman until May 31 (the end of the month in which her 60-day postpartum period ends). While Marianne is certified as a pregnant woman and exempt from copays, Joe will have the full individual monthly copay limit for their income tier, $26. After the end of the postpartum period, eligibility and copay limits will be redetermined. Beginning June 1, Marianne and Joe will each have the monthly prorated copay limit of $13.

If spouses are enrolled in two different health care programs (and both programs have a copay limit), the copay limit for the household will be calculated based on the assistance group with **lower** income and prorated between spouses. This will prevent the spouse with lower income from paying cost sharing expenses in excess of the five percent limit.

Example 3: Dave, his wife Debbie, and their son Derek receive health care benefits. Dave is enrolled in SSI-Related Medicaid and Debbie and Derek are enrolled in BadgerCare Plus under a BadgerCare Plus Extension. Due to the different income budgeting rules for SSI-Related Medicaid and BadgerCare Plus:

- The countable income for SSI-Related Medicaid is $1,400, which is 97% of the 2020 FPL for a group size of two. That puts the SSI-Related Medicaid assistance group income in the >50-100% of FPL income tier.
- The countable income for the BadgerCare Plus Extension is $2,885, which is 159% of the 2020 FPL for a group size of three. That puts the BadgerCare Plus assistance group income in the >150-200% of FPL income tier.

To determine the copay limit for the household, the lower SSI-Related assistance group income tier of 50-100% of FPL will be used. The $26 copay limit is prorated between Debbie and Dave, so they each have a $13 copay limit.

If a member who is enrolled in a health care program with a copay limit is married to someone who is enrolled in a program with no copay limit (MAPP or SeniorCare), the member will have the full individual copay limit for his or her income tier.

For members who are eligible for both QMB and a full benefit health care program with a copay limit, the income used to determine eligibility for the full benefit program will be used to calculate the member's copay limit.

Example 4: Dwayne is eligible for both SSI-Related Medicaid and Medicare. He also qualifies for QMB. Under SSI-Related Medicaid, Dwayne's income is in the >50-100% of FPL tier. His copay limit is $26 per month based on his SSI-Related Medicaid eligibility. Since QMB is a limited benefit program, no copay limit will be set for QMB.

If Dwayne were only eligible for QMB, his copay limit would be set based on the income used to determine his eligibility for QMB.

For members who pay a monthly premium, the premium amount will be subtracted automatically when the member's copay limit is calculated in CARES. For married couples with at least one spouse subject to CLA policy, the total household premium amount will be split evenly between the married couple even if the spouses are on different benefit programs.

Example 5: Mark is a CLA with income that falls in the >50-100% of FPL income tier. He is enrolled in BadgerCare Plus and pays an $8 monthly premium. His copay limit is calculated as $26 minus the $8 premium. Mark's monthly copay limit, after his premium has been deducted, is $18.

Example 6: Alice and Barry are married and both eligible for BadgerCare Plus as childless adults with income that falls in the >50-100% of FPL income tier, for a $26 copay limit that is prorated between Alice and Barry. They have a household premium of $6 because Alice completed a health survey and reported healthy habits while Barry did not. The $6 premium is split evenly and deducted from each member's copay limit by subtracting $3 from both. Alice and Barry each have a $10 copay limit.

Alice suffers injuries from a car accident. She is verified as disabled and becomes eligible for SSI-Related Medicaid. Because Alice is no longer a childless adult, her health survey response does not result in a premium reduction for the household. If the household's income is still above 50% of the FPL, Barry's household premium will increase to $8. The $8 premium will be split evenly and deducted from both Alice and Barry's copay limits.

COPAY LIMITS FOR GROUP B AND B+ HOME AND COMMUNITY BASED WAIVER MEMBERS

For Group B and B+ Home and Community Based Waiver members, the copay limit will be based on the member's cost share amount for Waiver services rather than the income used to determine the member's eligibility.

- If the Waiver services cost share amount is less than $27 (the full individual copay limit for the >50-100% of FPL income tier plus one dollar), the Group B or B+ Waiver member will have the copay limit for the 0-50% of FPL income tier ($0).

- If the Waiver services cost share amount is $27 or greater, the Group B or B+ Waiver member will have the copay limit for the >50-100% of FPL income tier ($26).

Example 7: Marge is a Group B Waiver member. Her Waiver cost share amount is $15. Because this amount is less than $27, Marge's copay limit is $0, which means that she will not be charged any copays.

Example 8: George is a Group B Waiver member. His Waiver cost share amount is $120. George's copay limit is $26 because is his cost share amount is greater than $27.

If a Group B or B+ Waiver member is married to someone who is also a Group B or B+ Waiver member or is enrolled in a BadgerCare Plus or another EBD Medicaid subprogram with a copay limit (and who is not exempt from copays), the copay limit calculated for the spouse in the lower copay limit tier will be prorated between the two spouses.

Example 9: If Marge and George in examples 7 and 8 above were a married couple, the copay limit for the household would be based on the spouse in the lower copay limit tier (in this case, Marge). Marge and George would therefore each have a copay limit of $0.

Example 10: Trevor and Kate are married and enrolled in different health care benefits. Trevor is eligible for SSI-Related Medicaid and his income falls in the >0-50% FPL tier. Kate is eligible for Community Waivers Group B. Her Waiver cost share amount is $65. Since Trevor's income would be in a lower FPL tier than Kate's Waiver cost share amount, Trevor and Kate would each have a copay limit of $0.

If a Group B or B+ Waiver member is married to someone who is enrolled in a program with no copay limit (MAPP or SeniorCare), the Waiver member will have the full individual copay limit for his or her copay limit tier.

Example 11: Steve and Angela are a married couple. Steve is a Group B+ Waiver member and Angela is enrolled in MAPP. Steve's Waiver cost share amount is $30, so his copay limit is $26 based on the >50-100% of FPL income tier. Angela has no copay limit.

COPAY LIMITS FOR SSI MEDICAID MEMBERS

For SSI Medicaid members, whose Medicaid eligibility is determined by the Social Security Administration (SSA) rather than income maintenance agencies, per-member copay limits will be based on the >50-100% of FPL income tier. For 2020, these numbers are:

- $26 for an SSI Medicaid member who is single or married to a person who does not receive SSI Medicaid (individual limit)
- $13 for an SSI Medicaid member who is married and both spouses receive SSI Medicaid (prorated limit)

If an SSI Medicaid member is married to someone who is enrolled in BadgerCare Plus or an EBD Medicaid subprogram with a copay limit, each spouse's copay limit will be calculated individually and the copay limit will not be prorated between spouses.

Example 12: Chantal and Peter are married and both are receiving health care benefits. Chantal is eligible for SSI Medicaid and Peter is eligible for SSI-Related Medicaid and his income falls into the >50-100% of the FPL tier. Chantal and Peter will each have individual copay limits of $26.

NOTIFYING THE MEMBER OF THE COPAY LIMIT

CARES will set the member's copay limit when eligibility is determined or, for SSI Medicaid members, when the member's eligibility information is received from the SSA. After confirmation, the copay limit will be sent to interChange through the nightly batch process. The member's copay limit will be included on the Notice of Decision or SSA Approval letter.

CHANGES TO THE COPAY LIMIT

Once determined, the copay limit will remain the same from month to month unless there are changes that affect the copay limit, such as a change in income, assistance group size, or eligibility category. Increases in copay limits may not be made without providing timely notice to the member. Members have the right to appeal their monthly copay limit.

If a change results in a decrease in the monthly copay limit, the decrease should be effective during the month in which the change occurred or, if the change was reported untimely, the month in which the change was reported, whichever is later.

Example 13: Lucy is a CLA eligible for BadgerCare Plus with income at 90% of FPL, with a monthly copay limit set at $26. Lucy has a drop in income during January and her income is at 45% of FPL. Lucy does not report her decrease in income until March 21. Because Lucy did not report her loss of income until March 21, her copay limit will decrease to $0 effective March 1.

COPAY LIMIT MET LETTERS

Members will be notified when they have incurred enough copays before the end of the month to meet their monthly copay limit. The purpose of the letter is to prevent members from incurring additional cost sharing expenses that exceed the limit in that month. If, due to delays in providers submitting claims to Medicaid, the state learns that a member met a copay limit in an earlier month, no notification is

required. The letter informing the member that the copay limit has been met is informational only, and members may not appeal the date the copay limit was determined to have been met.

Example 14: Tamika is enrolled in BadgerCare Plus and has a copay limit of $13 for the month of August. On August 12, interChange notifies CARES that Tamika has met her copay limit of $13. CARES issues Tamika an automated notice stating that her $13 copay limit has been met for the month of August and that she will have no copays for the remainder of the month. On August 21, Tamika has a doctor's appointment. She will have no copay for the doctor's appointment since her copay limit has already been met for the month of August. On September 1, Tamika will be responsible for copays incurred until her monthly limit is met.

Tracking of whether a member had incurred copayments in excess of their limit will be handled by interChange. Providers will be informed when a member was not responsible for a copayment for a service they received. If the member actually paid the copay to the provider when they should not have had a copay, the provider will be required to reimburse the member the amount of the copayment.

Note: Once a copay limit is met for a given month, it will never become "unmet" in the same month, and the member will not be charged any more copays in that month.

CONVERSION

A data conversion process will run in CARES on June 6, 2020, to calculate copay caps for all relevant health care assistance groups in CARES starting with the July 2020 benefit month. Copay cap information will be sent to interChange along with member eligibility information.

CONTACTS

BEPS CARES Information and Problem Resolution Center

DHS/DMS/BEPS/PH