133.000  Cost Sharing  9-15-09

The forms of cost sharing in the Medicaid Program are coinsurance, co-payment, deductibles and premiums. Each are detailed in the following Sections 133.100 through 133.500.

133.100  Inpatient Hospital Coinsurance Charge for Medicaid Beneficiaries  6-1-08
Without Medicare

For inpatient admissions, the Medicaid coinsurance charge per admission for non-exempt Medicaid beneficiaries aged 18 and older is 10% of the hospital's interim Medicaid per diem, applied on the first Medicaid covered day. (See Section 124.230 for Working Disabled cost-sharing requirements.)

Example:

A Medicaid beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid interim per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00; the beneficiary will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).

133.200  Inpatient Hospital Coinsurance Charge to ARKids First-B Beneficiaries  7-1-11

For inpatient admissions, the coinsurance charge per admission for ARKids First-B participants is 10% of the hospital's Medicaid per diem, applied on the first covered day.

Example:

An ARKids First-B beneficiary is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem is $500.00. When the hospital files a claim for 4 days, Medicaid will pay $1950.00 and the beneficiary will pay $50.00 (10% Medicaid coinsurance rate).

1. Four (4 days) times $500.00 (the hospital per diem) = $2000.00 (hospital allowed amount).
2. Ten percent (10% Medicaid coinsurance rate) of $500.00 = $50.00 coinsurance.
3. Two thousand dollars ($2000.00 hospital allowed amount) minus $50.00 (coinsurance) = $1950.00 (Medicaid payment).
The coinsurance charge per admission for Medicaid beneficiaries, who are also Medicare Part A beneficiaries, is 10% of the hospital’s Arkansas Medicaid per diem amount, applied on the first Medicare covered day only.

Example:
A Medicare beneficiary, also eligible for Medicaid, is an inpatient for 4 days in a hospital whose Arkansas Medicaid per diem amount is $500.00.

1. This is the patient’s first hospitalization for the Medicare benefit year; so the patient has not met their Medicare Part A deductible.
2. Medicare pays the hospital its allowed Part A charges, less the current (federal fiscal year) Medicare deductible, and forwards the payment information to Medicaid.
3. Ten percent (10% Medicaid coinsurance rate) of $500.00 (the Arkansas Medicaid hospital per diem) = $50.00 (Medicaid coinsurance). Medicaid coinsurance is due for the first day only of each admission covered by Medicare Part A.
4. Medicaid’s payment is the current (federal fiscal year) Medicare Part A deductible minus $50.00 Medicaid coinsurance.

If, on a subsequent admission, Medicare Part A assesses coinsurance, Medicaid will deduct from the Medicaid payment an amount equal to 10% of the hospital’s Medicaid per diem for one day. The patient will be responsible for the amount deducted from the Medicaid payment.

Arkansas Medicaid has a beneficiary co-payment requirement in the Pharmacy Program. The payment is applied per prescription. Non-exempt beneficiaries aged 18 and older are responsible for paying the provider a co-payment amount based on the following table: (See Section 124.230 for Working Disabled cost-sharing requirements. See the ARKids First-B provider manual for ARKids-First B cost-sharing requirements.)

<table>
<thead>
<tr>
<th>Medicaid Maximum Amount</th>
<th>Beneficiary Co-pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10.00 or less</td>
<td>$0.50</td>
</tr>
<tr>
<td>$10.01 to $25.00</td>
<td>$1.00</td>
</tr>
<tr>
<td>$25.01 to $50.00</td>
<td>$2.00</td>
</tr>
<tr>
<td>$50.01 or more</td>
<td>$3.00</td>
</tr>
</tbody>
</table>

Arkansas Medicaid has a beneficiary co-payment requirement in the Visual Care Program. Medicaid beneficiaries 21 years of age and older must pay a $2.00 co-payment for Visual Care prescription services. Nursing home residents are exempt from the co-pay requirement.