Managed Care Copayment FAQ & Quick Reference Guide for Providers

As of 11/1/18

Version 1.0

***Intended to be used by**: Commonwealth Provider Call Centers, MCOs and Kentucky Medicaid Providers as necessary.*

Reference guide updates:

- 11/1/18 – V1.0 FAQ and Reference Guide Completed

1. How will providers know whether an individual Medicaid beneficiary has a copay?

System Access

Step 1: Log into KY HealthNet through the Kentucky Medicaid Management Information System (KYMMIS) at http://kymmis.com/kymmis/index.aspx

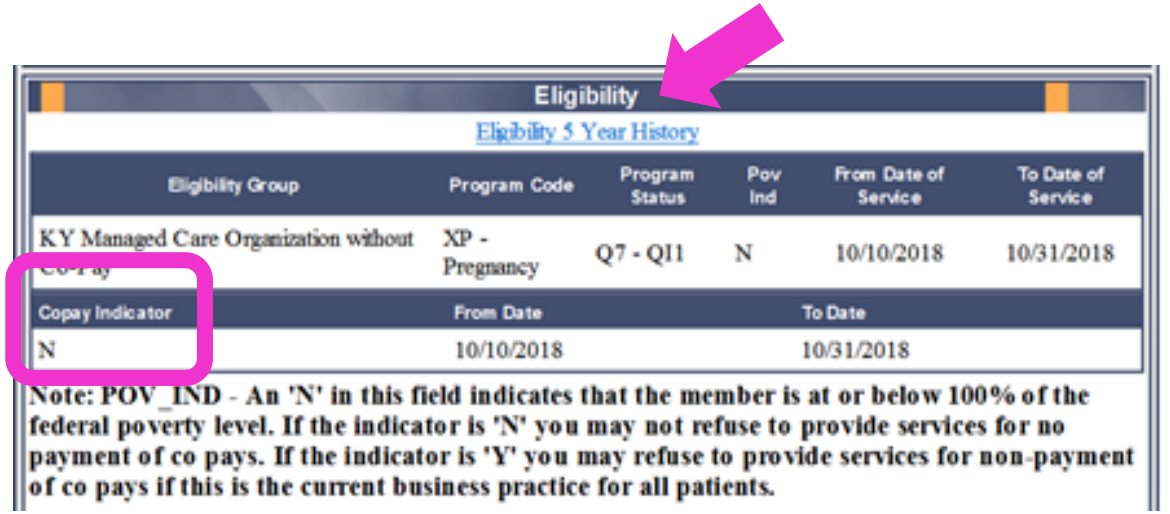
Step 2: Select "Eligibility Verification" (either from the menu bar or the left hand navigation)

Step 3: Select a lookup type, enter the dates and click the Search button.

Copay Indicator

Reference the **Eligibility** panel within KY HealthNet.

- If the **copay indicator is "N",** then the member is not subject to co-payments. **STOP here**.
- If the **copay indicator is "Y",** then the member is subject to co-payments if they have not met their quarterly cost share limit. There will be a link to a list of Copay Amounts.
  - **If copay indicator is "Y", provider must check the Cost Share Met Indicator (see next page.)**



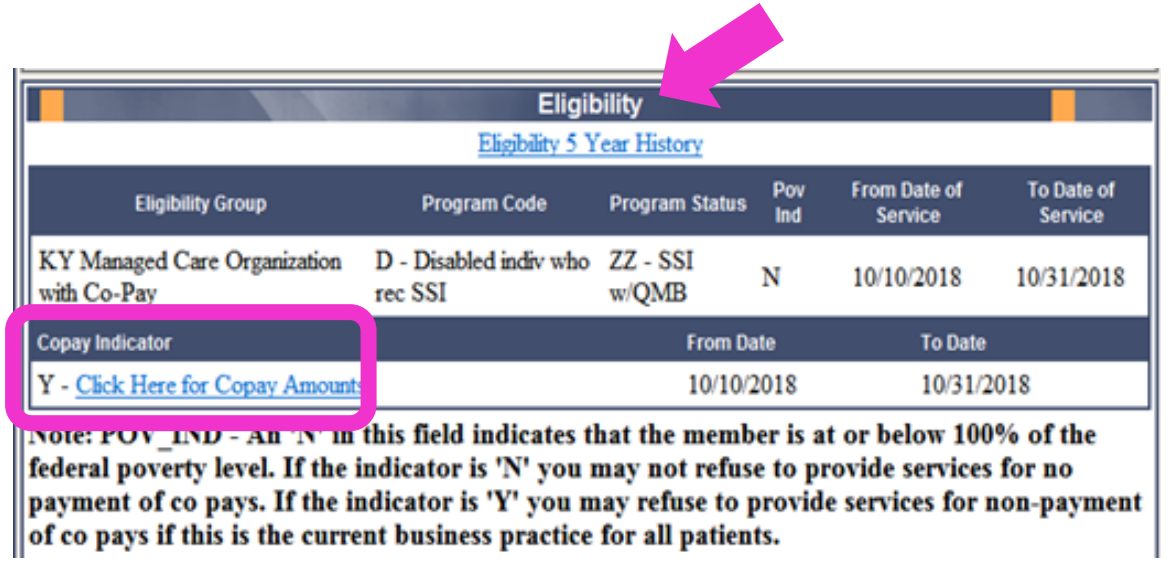
Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XP - Pregnancy	Q7 - QI1	N	10/10/2018	10/31/2018

Copay Indicator	From Date	To Date
N	10/10/2018	10/31/2018

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.



Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization with Co-Pay	D - Disabled indiv who rec SSI	ZZ - SSI w/QMB	N	10/10/2018	10/31/2018

Copay Indicator	From Date	To Date
Y - Click Here for Copay Amounts	10/10/2018	10/31/2018

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.

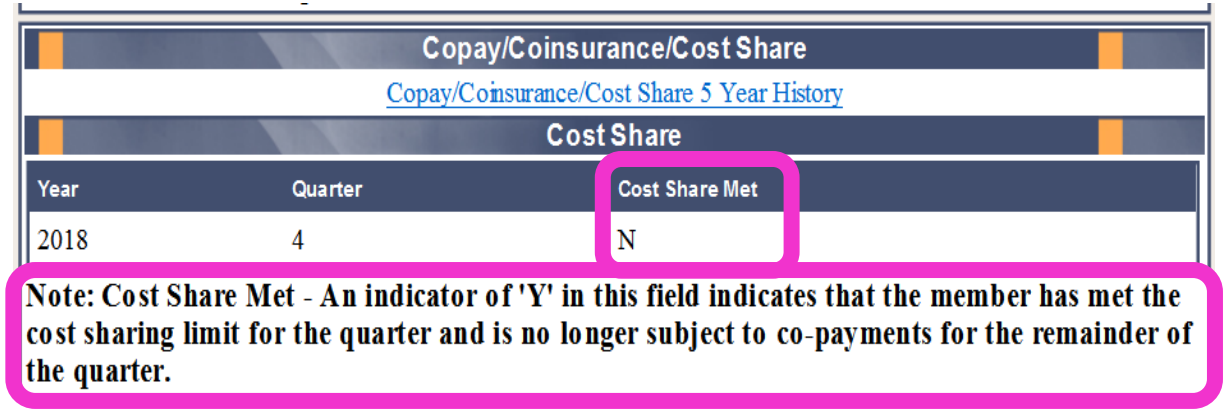
1 (cont). How will providers know whether an individual Medicaid beneficiary has a copay?

Cost Share Limit Indicator
Reference the **Cost Share** panel within KY HealthNet.

- If the **cost share met indicator is "Y", then the no more copayments are to be collected** because the member has reached his/her limit. **STOP here.**
- If the cost share met indicator is "N", then continue collecting copayments.

Note: If the copay is waived due to Cost Share Limit, the provider will still be fully reimbursed for the service.

The **Copay/Coinsurance/Cost Share 5 Year History** link provides a 5 year lookback showing whether the beneficiary has or has not met the cost-share limit.



Copay/Coinsurance/Cost Share

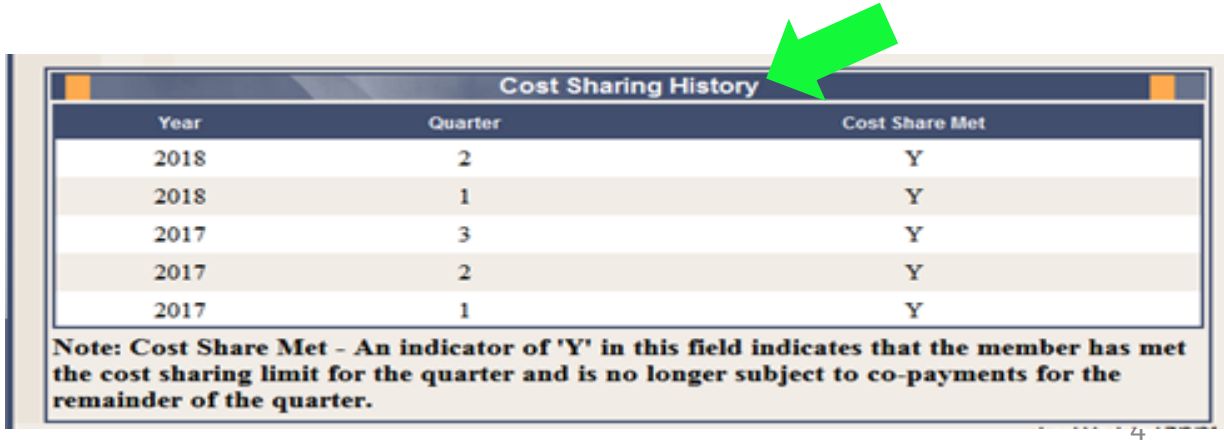
Copay/Coinsurance/Cost Share 5 Year History

Cost Share

Year	Quarter	Cost Share Met
2018	4	N

Note: Cost Share Met - An indicator of 'Y' in this field indicates that the member has met the cost sharing limit for the quarter and is no longer subject to co-payments for the remainder of the quarter.

NOTE: The system will only display the cost share indicator value for the quarter(s) within the From and To dates entered at the top of eligibility. If looking up a whole year, it would display all 4 quarters, if only looking up one month, it would only display the appropriate quarter for that month.



Cost Sharing History

Year	Quarter	Cost Share Met
2018	2	Y
2018	1	Y
2017	3	Y
2017	2	Y
2017	1	Y

Note: Cost Share Met - An indicator of 'Y' in this field indicates that the member has met the cost sharing limit for the quarter and is no longer subject to co-payments for the remainder of the quarter.

2. How will providers know which specific services require copays?

- MCOs shall impose copayments on all Copayment Plan Members.
- In accordance with 42 CFR 447.52, providers may not deny care or services to any Member at or below one hundred percent (100%) FPL because of his or her inability to pay the copayment.

Service or Item	Copayment Amount
Brand Name Drug	$4.00
Generic Drug	$1.00
Brand Name Drug Preferred Over Generic	$1.00
Chiropractor	$3.00
Dental – for Members not enrolled in the Alternative Benefit Plan	$3.00
Podiatry	$3.00
Optometry – for Members not enrolled in the Alternative Benefit Plan	$3.00
General ophthalmological services – for Members not enrolled in the Alternative Benefit Plan	$3.00
Office visit for care by a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife, or any behavioral health professional	$3.00

Service or Item	Copayment Amount
Physician service	$3.00
Visit to a rural health clinic, primary care center, or federally qualified health center	$3.00
Outpatient hospital service	$4.00
Emergency room visit for a non-emergency service	$8.00
All Inpatient hospital admission	$50.00
Physical therapy, speech therapy, occupational therapy	$3.00
Durable medical equipment	$4.00
Ambulatory surgical center	$4.00
Laboratory, diagnostic, or x-ray service	$3.00

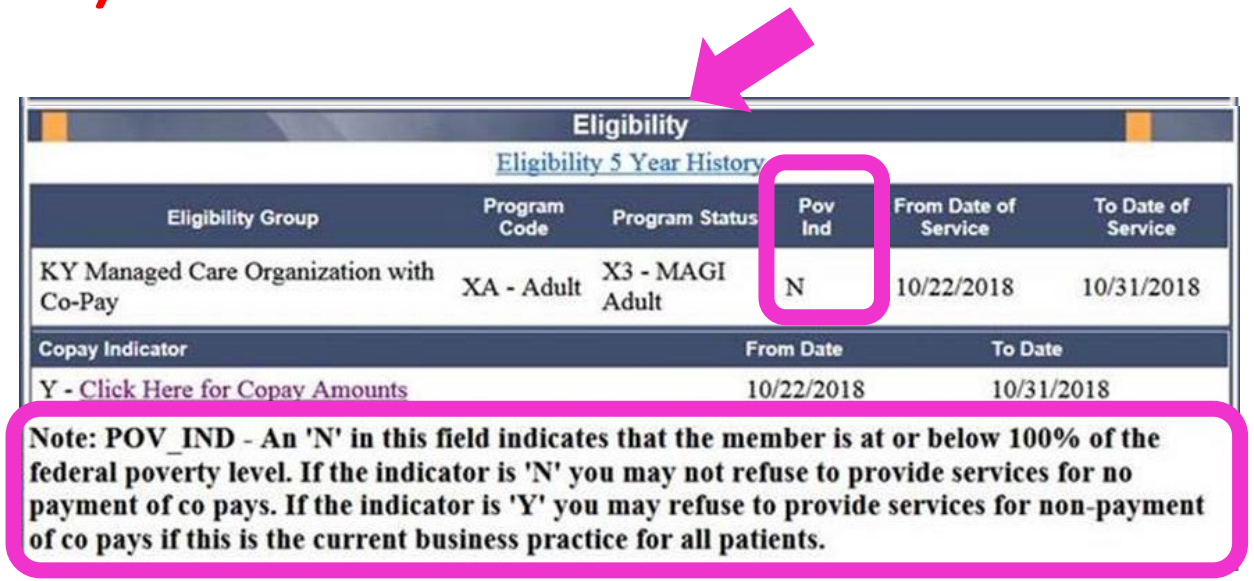
- Additional details can be found at on pages 8 – 10 of this guide.

3. How will providers know if a beneficiary is under or over 100% Federal Poverty Level (FPL)?

Reference the **Eligibility** panel within KY HealthNet. The "Pov Ind" column identifies whether a beneficiary is under 100% FPL. There is a note within this panel that includes a description of the poverty indicator.

- If the beneficiary **is below 100%** of the FPL, the Poverty Indicator (Pov Ind), will display a **N**. **Service cannot be denied**.

- If the beneficiary **is above 100%** of the FPL, the Poverty Indicator (Pov Ind), will display a **Y**. It is up to the provider whether they deny services. Services may only be denied for failure to pay if that is the current business practice for all patients. **Pregnant women and children can never be refused services for inability to pay.**



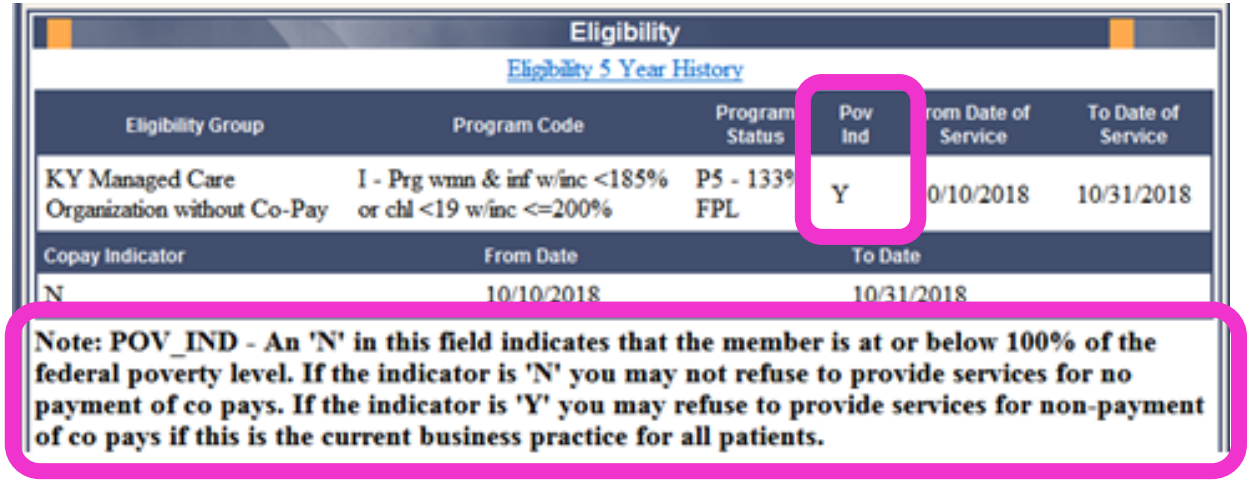
Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization with Co-Pay	XA - Adult	X3 - MAGI Adult	N	10/22/2018	10/31/2018

Copay Indicator	From Date	To Date
Y - Click Here for Copay Amounts	10/22/2018	10/31/2018

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.



Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	I - Prg wmn & inf w/inc <185% or chl <19 w/inc <=200%	P5 - 133% FPL	Y	10/10/2018	10/31/2018

Copay Indicator	From Date	To Date
N	10/10/2018	10/31/2018

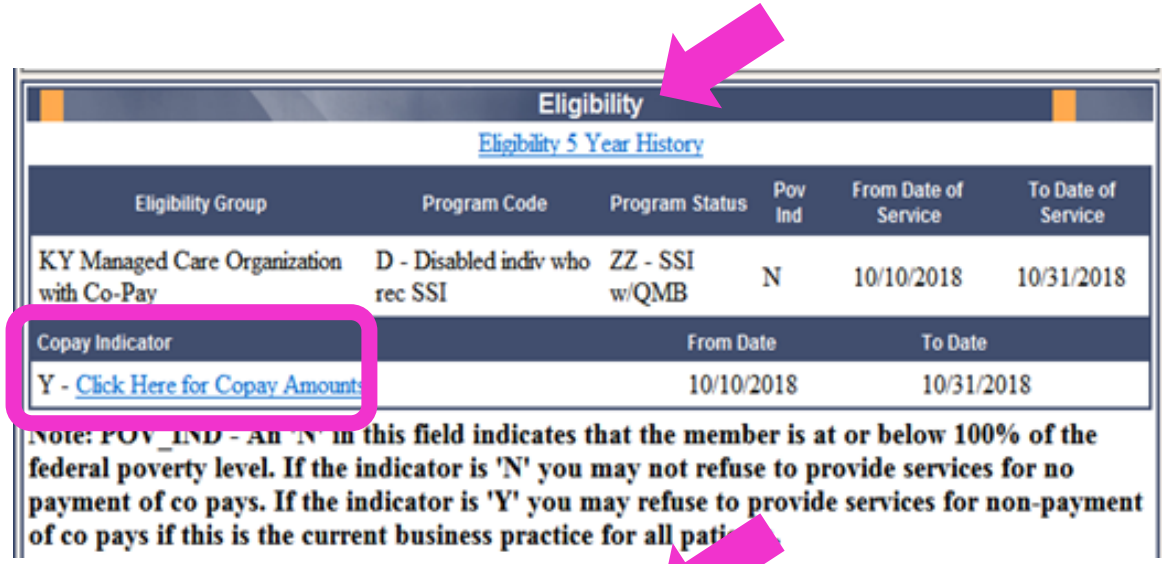
Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.

4. How will providers know if a beneficiary is part of one of the copay exempt groups?

Copay Indicator

Reference the **Eligibility** panel within KY HealthNet.

- If the beneficiary **has a copay,** the Copay Indicator section will display a **Y** with a link to a list of Copay Amounts.
- If the beneficiary **does NOT have a copay,** the Copay Indicator section will display a **N**.



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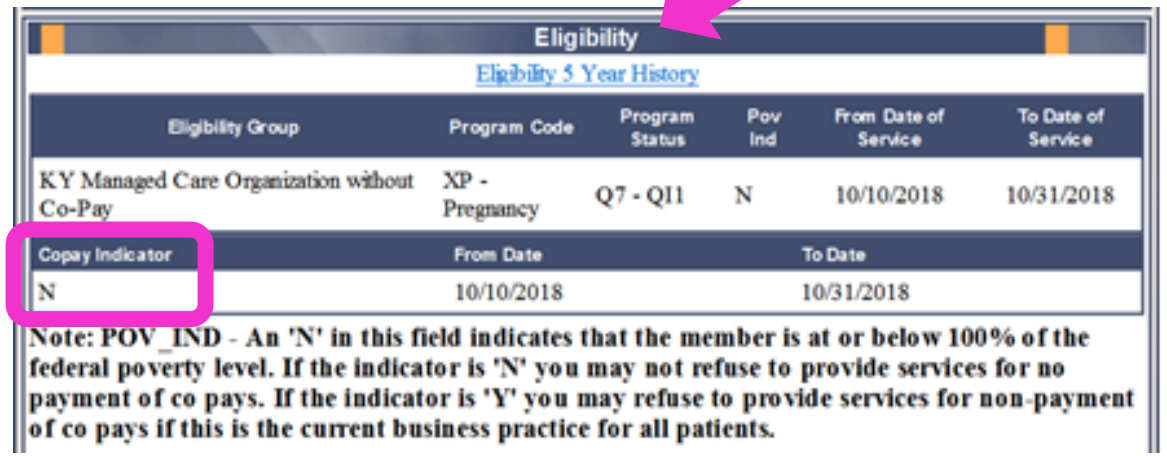
Copay Indicator	From Date	To Date
Y - Click Here for Copay Amounts	10/10/2018	10/31/2018

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all pati



Eligibility

Eligibility 5 Year History

Eligibility Group	Program Code	Program Status	Pov Ind	From Date of Service	To Date of Service
KY Managed Care Organization without Co-Pay	XP - Pregnancy	Q7 - QI1	N	10/10/2018	10/31/2018

Copay Indicator	From Date	To Date
N	10/10/2018	10/31/2018

Note: POV_IND - An 'N' in this field indicates that the member is at or below 100% of the federal poverty level. If the indicator is 'N' you may not refuse to provide services for no payment of co pays. If the indicator is 'Y' you may refuse to provide services for non-payment of co pays if this is the current business practice for all patients.

The MCOs shall impose copayments on all Copayment Plan Members. The copayment schedule is as shown in the table below.

Service or Item	Copayment Amount
Brand Name Drug	$4.00
Generic Drug	$1.00
Brand Name Drug Preferred Over Generic	$1.00
Chiropractor	$3.00
Dental – for Members not enrolled in the Alternative Benefit Plan	$3.00
Podiatry	$3.00
Optometry – for Members not enrolled in the Alternative Benefit Plan	$3.00
General ophthalmological services – for Members not enrolled in the Alternative Benefit Plan	$3.00
Office visit for care by a physician, physician's assistant, advanced registered nurse practitioner, certified pediatric and family nurse practitioner, nurse midwife, or any behavioral health professional	$3.00
Physician service	$3.00
Visit to a rural health clinic, primary care center, or federally qualified health center	$3.00
Outpatient hospital service	$4.00
Emergency room visit for a non-emergency service	$8.00
All Inpatient hospital admission	$50.00
Physical therapy, speech therapy, occupational therapy	$3.00
Durable medical equipment	$4.00
Ambulatory surgical center	$4.00
Laboratory, diagnostic, or x-ray service	$3.00

In accordance with 42 CFR §447.52, providers may not deny care or services to any Member at or below one hundred percent (100%) FPL because of his or her inability to pay the copayment.

The MCO shall ensure copayments are not imposed on the following exempt services

A. Emergency services as defined at Section 1932(b)(2) of the Social Security Act and 42 CFR §438.114(a);
B. Family planning services and supplies described in Section 1905(a)(4)(C) of the Social Security Act, including contraceptives and pharmaceuticals for which the State can claim enhanced federal match under Section 1903(a)(5) of the Social Security Act;
C. Preventive Services, defined as (i) all the preventive services assigned a grade of A or B by the United States Preventive Services Task Force (USPSTF); or (ii) all approved adult vaccines, including their administration, recommended by the Advisory Committee on Immunization Practices; or (iii) preventive care and screening recommended by the Health Resources and Services Administration Bright Future Program Project; or (iv) preventive services recommended by the Institute of Medicine;
D. Pregnancy-related services; and
E. Provider-preventable services as defined in 42 CFR §447.26(b).

In imposing the eight-dollar ($8.00) copayment for an emergency room (ER) visit for a non-emergent service, the Contractor shall ensure compliance with 42 CFR §447.54 and Section 42.12. The Contractor shall consider an ER visit emergent, for purposes of waiving the copayment, if the member had a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

A. Placing the health of the Member (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

The Contractor shall not limit what constitutes a non-emergent visit, for purposes of imposition of the copayment, on the basis of lists of diagnoses or symptoms
Further clarification can be found in 907 KAR 1:604 Recipient cost sharing.

Additional Information Regarding Pharmacy Copays:

Copays by Product Class – products in these classes are subject to exceptions or exemptions from the brand/generic rules.

A. Certain Antipsychotics: $1.00;
    i. Atypical Antipsychotics (mostly second gen),
    ii. Many Long-acting injectables, and

iii. Other products in this class.

B. Contraceptives for family planning: $0.00
C. Tobacco Cessation:$0.00
D. Diabetes supplies:
   i. Blood Glucose Meters: $0.00
   ii. All other covered diabetic supplies: $4.00 for 1st fill; $0.00 for 2nd fill and beyond, PER DAY, on a first submitted claim basis