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| LOCAL COMMISSIONERS MEMORANDUM |
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DSS-4037EL (Rev. 9/89)

Transmittal No: 95 LCM-68

Date: June 30, 1995

Division: Health and Long
Term Care

TO: Local District Commissioners

SUBJECT: Pharmacy Co-Payments for Medicaid Recipients

ATTACHMENTS: Medicaid Co-Payment Fact Sheet
(English and Spanish) (On-line)

CONTACT: Policy and Procedure Questions should be directed to
the Bureau of Ambulatory Policy and Utilization Review
at 1-800-343-8859, ext. 3-5983.
WMS Questions should be directed to Dennis DiMuria at
1-800-343-8859, ext. 3-5614.

The purpose of this Local Commissioners Memorandum (LCM) is to inform you that on September 1, 1995, Medicaid co-payments will be extended to pharmacy services and supplies. Refer to 93 LCM-119 and 93 LCM-125 for additional information on the Medicaid Co-Payment Program.

Due to an adverse court decision the New York State Department of Social Services (the Department) was unable to implement pharmacy co-pay when the program first began on November 1, 1993. However, since the court's decision was based on federal legislation which expired on December 31, 1994, the Department is now able to implement this part of the co-pay program. Also, the Social Services Law authorizing the co-pay program has been extended from July 30, 1995 until July 30, 1997.

This LCM provides a description of pharmacy co-payment requirements. The only action required by social services departments will be the distribution of the "Medicaid Co-Payment Fact Sheet" (Attachment) at the time of application and authorizing "Aid to Continue" for recipients who request a State fair hearing on Medicaid co-payments.

Effective September 1, 1995, most Medicaid recipients age 21 or older may be asked to contribute to the cost of some drugs and medical supplies provided by pharmacies. Other existing co-payments and exemptions will continue uninterrupted. Information is being sent to all Medicaid enrolled pharmacies advising them of the implementation of pharmacy co-payments.

Medicaid providers cannot refuse to give goods or services based on a recipient's stated inability to pay the co-payment amount. However, the recipient is still responsible for any unpaid co-pay amounts and may still be billed or asked for these payments at a later time.

A "Dear Medicaid Recipient" letter explaining the new program requirements will be mailed by the Department beginning in early August 1995 to the heads of households of all Public Assistance and Medical Assistance Only cases appearing eligible on the WMS system on July 7, 1995. Nursing home recipients will be excluded from this mailing because they are exempt from co-payments.

Copies of both the "Dear Medicaid Recipient" letter and the "Dear Pharmacy Provider" letter will be sent to you under a separate LCM.

Effective July 10, 1995, social services departments must distribute the attached Medicaid Co-Payment Fact Sheet, along with the application packet, to all PA and MA Only applicants. The "Medicaid Fact Sheet" must be locally reproduced. Revised Client Booklets which include all the necessary co-payment client information are currently being printed. When you receive them, you will no longer be required to distribute the attached Fact Sheet to new applicants.

Additionally, social services departments should note that all co-payments, including pharmacy co-payments, should be applied toward an applicant's/recipient's spenddown when determining financial eligibility for Medical Assistance. Recipients have been instructed to save all co-payment receipts, including pharmacy co-payment receipts.

Following are the major highlights of the pharmacy co-payment program. Refer to the attached document (Medicaid Co-Payment Fact Sheet) for further details on the program.

Pharmacy Co-payments will apply to the following services only:

Prescription drugs, nonprescription (over-the-counter) drugs and sickroom supplies dispensed by a pharmacy;

Exceptions:

- Psychotropic drugs, as defined by the Department;
- Family Planning drugs and supplies;
- FDA approved drugs for the treatment of TB.

Co-payment amounts are as follows:

<u>Prescription drugs and Supplies</u>	<u>Amount (\$)</u>
Generic	0.50 per prescription
Brand Name	2.00 per prescription
Psychotropic	NO CO-PAYMENT
Family Planning drugs	NO CO-PAYMENT
TB Drugs	NO CO-PAYMENT
Nonprescription Drugs (over-the-counter)	0.50 per order
Enteral/Parenteral Formulae and Supplies	1.00 per order/prescription
Medical/Surgical Supplies (e.g. ostomy bags)	1.00 per order

Note: For each 12 month period, there is a maximum per recipient of \$100 for ALL co-payments, including pharmacy co-payments. The co-pay year runs from April 1 through March 31 regardless of when the recipient became eligible for Medicaid payments. All co-payments, including pharmacy co-payments, are counted when calculating the \$100 cap. When the \$100 maximum is reached for the year, the Department will notify the recipient by letter that the maximum co-payment has been reached. The co-pay amount(s) count toward the \$100 maximum regardless of whether they are paid or unpaid to the provider. Providers are notified through EMEVS when the recipient has reached the \$100 cap.

Recipients exempt from co-payment under the co-pay program including pharmacy co-pay include the following:

- o Recipients under the age of twenty-one;
- o Pregnant women (this exemption continues for two months after the month in which the pregnancy ends);
- o Recipients institutionalized in a medical facility who are required to spend all of their income, except for a personal needs allowance, on medical care. This includes all recipients in Nursing Facilities and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);

- o Recipients enrolled with Medicaid Managed Care Plans;
- o Residents of OMH and OMRDD certified community residences and recipients enrolled in Comprehensive Medicaid Case Management Program (CMCM) or OMRDD Home and Community Based Services (HCBS) waiver programs;
- o Recipients who request a Fair Hearing and are eligible for Aid Continuing benefits;
- o Recipients who have reached the \$100 maximum for that year.

Exempt services under the co-pay program including pharmacy co-pay include the following:

- o Emergency services;
- o Family Planning services;
- o Psychotropic drugs as defined by the Department;
- o Tuberculosis Directly Observed Therapy;
- o FDA approved drugs used for the treatment of Tuberculosis;
- o Methadone Maintenance Treatment Programs (MMTP), mental health clinic services, mental retardation clinic services, alcohol and substance abuse clinic services.

Note: There is no co-payment for services provided by private practicing physicians or private practicing dentists. There is also no co-payment on home health and personal care services.

FAIR HEARINGS:

Certain Medicaid recipients may be entitled to a fair hearing if they disagree with the co-payment charge. Since this change is required by section 367-a(6) of the Social Services Law, if the only issue the recipient is asking to be reviewed at a hearing is the change in law itself, the hearing officer may decide that the Medicaid recipient does not have a right to a fair hearing. However, a Medicaid recipient does have a right to a fair hearing if we made a mistake about the recipient's date of birth or whether the recipient is a resident of a Nursing Facility, an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), a community based residential facility licensed by the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD) or whether the recipient is enrolled in a Comprehensive Case Management Program (CMCM), a Home and Community Based (HCBS) waiver program, or a Medicaid Managed Care Plan.

Recipients who request a Fair Hearing before September 1, 1995, are entitled to Aid Continuing. Recipients who are eligible for Aid Continuing benefits are exempt from co-pay at least until a Fair Hearing decision has been issued by the Department. Recipients who request a Fair Hearing after September 1, 1995, are also entitled to a Fair Hearing. Eligibility for Aid Continuing for persons who request a Fair Hearing after September 1, 1995, will be determined on a case by case basis.

WMS Instructions:

Note: The following information supersedes the WMS instructions contained in 93 LCM-146, dated October 22, 1993.

WMS Exception Code 39 was developed to exempt recipients who have Aid Continuing from co-pay requirements.

WMS Instructions for input of Restriction/Exception Code 39 - Aid Continuing are as follows:

Accessing the Restriction/Exception Subsystem

- Access the Medical Assistance Menu by choosing selection 25 on the WMS menu.
- Access the Restriction/Exception by typing "R" in the subsystem selection.
- Select the function "Input": Type "I".
- Enter CIN, Case Number and Worker I.D. Number.
- Transmit.

Entry of Individual in Aid-Continuing Status (Exception Code 39)

- Enter the R/E Code 39 (aid continuing) in the RE/EXC TYPE field.
- The RE/EXC PERIOD FROM DATE is entered equal to the first day the A/R is in aid-continuing status.
- Transmit the information and review for accuracy.
- Store the accurate data using SF13.

Inactivation of an Erroneous Entry

- Access the RE/EXC subsystem.
- Enter the RE/EXC type of the inactivation (code 39).

-Enter the RE/EXC PERIOD THRU date equal to the RE/EXC FROM DATE.

-Transmit and review the data.

-Store the accurate date using SF13.

Termination of Code 39

-Access the RE/EXC subsystem Input screen.

-Enter the restriction type (39) and the termination date in the period THRU field.

-Transmit and review the data.

-Store the accurate data using SF13.

Note: Code 39 must be terminated for individuals who lose their Fair Hearing and are consequently responsible for the co-pay.

Richard T. Cody
Deputy Commissioner
Division of Health and Long Term Care

July 10, 1995

MEDICAID CO-PAYMENT FACT SHEET

As you may be aware, most Medicaid recipients age 21 or older are asked to pay for part of the cost of their medical care each time they see a Medicaid provider. This payment is called a co-payment or co-pay. On September 1, 1995, pharmacies (also known as drug stores) will also ask recipients for co-payments.

IF YOU ARE UNABLE TO PAY THE REQUESTED CO-PAYMENT, TELL YOUR HEALTH CARE PROVIDER WHEN THE PROVIDER ASKS YOU FOR PAYMENT. YOU CAN STILL GET THE SERVICES YOU NEED FROM YOUR PROVIDER. THE PROVIDER CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS BECAUSE YOU TELL THE PROVIDER THAT YOU ARE UNABLE TO PAY THE CO-PAYMENT. Any unpaid co-pay amounts are money you still owe to the provider. In this case, the provider may at a later time ask you for the co-pay amount or send you a bill.

There is a toll free telephone number you can use to report providers who refuse to give you care because you are unable to pay the co-payment. The number is 1-800-541-2831 and can be called between 8:30 am and 5:00 pm on Monday through Friday.

There are a number of exemptions from co-payments. Please read this entire letter to see if you do not have to pay co-payments or if the services you need do not have co-payments.

Your pharmacy provider will be allowed to ask for co-payments for:

1. PRESCRIPTION DRUGS - The co-payment for each new prescription and each refill for a brand-name drug is \$2.00. The co-payment for each prescription and each refill for a generic drug is \$0.50. There is no co-payment for certain drugs to treat mental illness or tuberculosis. Your pharmacist can tell you if there is a co-payment for the drug you need, and if the drug is a brand-name or generic drug.
2. NONPRESCRIPTION DRUGS - The co-payment for each new order and each refill for a nonprescription (also known as over-the-counter) drug is \$0.50. If you do not know if the drug you need is a nonprescription drug, ask your pharmacist.
3. SICKROOM SUPPLIES - The co-payment for each new order and each refill for a sickroom supply is \$1.00. Sickroom supplies include ostomy bags, heating pads, bandages, gloves, vaporizers, syringes, etc.

Co-payments have been in place since November 1, 1993 and will continue to be required for the following services:

1. INPATIENT HOSPITAL CARE - The co-payment for each hospital stay (if you have to stay one or more nights) is \$25. You may be asked for this co-payment when you leave the hospital.

2. EMERGENCY ROOM VISITS - The co-payment for each visit for non-emergency or non-urgent visit to an emergency room is \$3.00. If you get emergency or urgent care in the emergency room, you will not have to pay a co-payment. The emergency room will decide whether you are getting emergency or urgent care.
- 3 CLINIC VISITS - The co-payment for each clinic visit is \$3.00. Visits to clinics for mental health services, developmental disabilities/mental retardation services, alcohol and drug abuse services, Tuberculosis Directly Observed Therapy, family planning and Methadone Maintenance Treatment Programs (MMTP) do not have a co-payment.
4. SICKROOM SUPPLIES The co-payment for each new order and each refill for a sickroom supply is \$1.00. Sickroom supplies include ostomy bags, heating pads, bandages, gloves, vaporizers, syringes, etc.
5. LABORATORY SERVICES - The co-payment for each laboratory procedure billed by a laboratory to Medicaid is \$0.50.
6. X-RAYS - The co-payment for each x-ray you get is \$1.00. If your doctor takes the x-ray in his or her office, there is no co-payment.

Note: There is no co-payment for services by private practicing physicians or dentists. There is also no co-payment for Home Health Services and Personal Care Services.

For each 12 months there is a \$100 maximum per recipient for all co-payments incurred. The co-pay year runs from April 1 through March 31, regardless of when you became eligible for Medicaid. The New York State Department of Social Services will record all the times your co-payment applies and inform providers if you reach the \$100 maximum for that year. The Department will also send you a letter if the maximum co-payment is reached.

If you are eligible for Medicaid by spending part of your income toward medical care, save your co-payment receipts. The co-payments you pay or incur will count toward your spenddown (overage) in the following month.

YOU DO NOT HAVE TO PAY THE CO-PAYMENT IF:

1. You are unable to pay and you tell your provider that you are unable to pay. Any unpaid co-pay amounts are money you still owe to the provider. In this case, the provider may at a later time ask you for the co-pay amount or send you a bill.
2. You are younger than 21 years of age.
3. You are pregnant. If you are pregnant, have your doctor give you a note that says you are pregnant. You can show this note to your other providers if they ask you for a co-payment. This exemption continues for two months after the month in which your pregnancy ends.
4. You are enrolled with a Medicaid managed care plan. Your local department of social services office can tell you if you belong to a Medicaid managed care plan, and if not, how you might be able to become a member. You continue to remain eligible for the full range of Medicaid covered services even if you do not enroll with a managed care plan. Currently, you are not required to enroll in a Medicaid managed care program unless you live in certain areas of Brooklyn.

Later this year recipients living in other parts of New York City and the state may also be required to enroll in a Medicaid Managed care plan. You will be sent a letter by your local department of social services if you are required to join. If anyone else tells that you must join a Medicaid managed care program in order to continue your benefits call 1-800-541-2831.

5. You are getting care or services for an emergency. This is care given to you to treat a severe life-threatening or a possibly disabling condition that needs immediate care.
6. You are getting family planning services (birth control). This includes family planning drugs or supplies such as birth control pills and condoms.
7. You are a resident of Nursing Facility or an Intermediate Care Facility for the Developmentally Disabled (ICF/DD).
8. You are enrolled in a Comprehensive Case Management Program (CMCM) or a Home and Community Based Services (HCBS) Waiver Program. These programs are associated with the Office of Mental Health (OMH) or the Office of Mental Retardation and Developmental Disabilities (OMRDD). You have a case manager if you are in either of the programs. The case manager can help you if you have any questions.
9. You are a resident of a community based residential facility licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disabilities and not already exempt by receiving CMCM or HCBS services. A staff member from your residence will give you a letter to show providers so you do not have to pay co-payment.
10. You reach the \$100 maximum for that year.

REMINDER: PROVIDERS CANNOT REFUSE TO GIVE YOU SERVICES OR GOODS IF YOU CANNOT PAY THE CO-PAYMENT AND TELL THIS TO THE PROVIDER.

10 de julio de 1995

RESUMEN DE DATOS SOBRE LOS COPAGOS DEL MEDICAID

Como usted ya debe saber, a la mayoría de los beneficiarios del Medicaid de 21 años de edad o más se les pide que paguen parte del costo de su atención médica cada vez que visiten a un proveedor(a) de beneficios del Medicaid. Este pago se llama "copago". A partir del 1 de septiembre de 1995 las farmacias (conocidas también como droguerías) solicitarán copagos de los beneficiarios.

SI USTED NO ESTA EN CONDICIONES DE PAGAR EL COPAGO REQUERIDO, DIGASELO A SU PROVEEDOR(A) DE SALUD CUANDO ESTE LE PIDA EL COPAGO. AUN EN ESTE CASO USTED PODRA OBTENER LOS SERVICIOS QUE NECESITA DE SU PROVEEDOR(A). EL PROVEEDOR(A) NO PUEDE REHUSARSE A PROVEERLE LOS SERVICIOS O A SUMINISTRARLE LOS ARTICULOS QUE USTED NECESITA DEBIDO A QUE USTED NO PUEDE SATISFACER EL COPAGO. Cualquier cantidad de copagos que no hayan sido pagados, es dinero que usted aún debe al proveedor(a). En este caso el proveedor(a) puede cobrarle el copago que usted deba o enviarle una cuenta.

Hay un número de teléfono gratuito que puede ser utilizado para denunciar a proveedores que se nieguen a proveerle atención debido a que usted no puede pagar el copago. El número es 1-800-541-2831, y éste teléfono funciona de Lunes a Viernes entre las 8:30 am y las 5:00 pm

Existen varias exenciones de copagos. Sírvase leer todo este resumen de datos para averiguar si usted o los servicios que usted necesita están exentos de copagos.

Su farmacia proveedora podrá solicitar copagos para:

1. MEDICAMENTOS CON RECETA - El copago por cada receta nueva y por cada reposición (refill) para un medicamento de marca registrada (brand-name) es \$2.00. El copago por cada receta y por cada reposición (refill) para un medicamento genérico es \$0.50. No se requieren copagos para ciertos medicamentos para el tratamiento de enfermedades mentales o tuberculosis. Su farmacéutico le puede informar si hay un copago por el medicamento que usted necesita y si el medicamento es de marca registrada (brand-name) o genérico.
2. MEDICAMENTOS SIN RECETA- El copago por cada nuevo pedido y por cada reposición (refill) de un medicamento sin receta (de venta libre) es \$0.50. Si usted no sabe si el medicamento que necesita no requiere receta para ser adquirido, pregúntele a su farmacéutico.
3. ARTICULOS DE ENFERMERIA- El copago por cada pedido nuevo y por cada reposición (refill) de artículos de enfermería es \$1.00. Artículos de enfermería incluyen bolsas quirúrgicas, almohadas calentadoras, vendas, guantes, vaporizadores, jeringas, etc.

Los copagos han estado en vigor desde el 1 de noviembre de 1993 y continuarán siendo un requisito para los servicios siguientes:

1. ESTADIA INTERNA EN UN HOSPITAL- El copago para cada ingreso en un hospital (si usted tiene que quedarse una o más noches) es \$25.00. Es posible que este copago se le solicite cuando usted salga del hospital.

2. SERVICIOS EN LA SALA DE EMERGENCIA- El copago por cada visita a la sala de emergencia por razones que no sean de emergencia o no sean urgentes es \$3.00. Si usted recibe servicios de emergencia o servicios de urgencia en la sala de emergencia, no se le requerirá un copago. En la sala de emergencia se decidirá si los servicios que usted está recibiendo son de emergencia o urgencia.
3. VISITAS A UNA CLINICA - El copago por cada visita a una clínica es \$3.00. Las visitas a una clínica para recibir servicios relacionados con la salud mental, incapacidad de desarrollo/retraso mental, alcohol o abuso de drogas, Terapia para la Tuberculosis Directamente Observada, planificación familiar y Programas de Tratamiento de Mantenimiento con Metadona (Methadone Maintenance Treatment Programs--MMTP), no requieren copagos.
4. ARTICULOS DE ENFERMERIA- El copago por cada pedido nuevo o por cada reposición (refill) de artículos de enfermería es \$1.00. Artículos de enfermería incluyen bolsas quirúrgicas, almohadas calentadoras, vendas, guantes, vaporizadores, jeringas etc.
5. SERVICIOS DE LABORATORIO- El copago por cada procedimiento que un laboratorio cobre a Medicaid es \$0.50.
6. RAYOS X - El copago por cada radiografía que usted reciba es \$1.00. Si su médico toma la radiografía en su propio consultorio, entonces no se requerirá copago.

NOTA: Los servicios provistos por médicos o dentistas en consulta privada no requieren copago. Los Servicios de Salud a Domicilio (Home Health Services) y los Servicios de Cuidado Personal (Personal Care Services) tampoco requieren copago.

Por cada 12 meses hay un máximo de \$100 por beneficiario(a) para todos los copagos incurridos. El año relativo a copagos transcurre desde el 1 de abril hasta el 31 de marzo sin tomar en cuenta la fecha en la que usted empezó a ser elegible para el Medicaid. El Departamento de Servicios Sociales del Estado de Nueva York llevará un registro de todas las veces que su copago se aplique e informará a sus proveedores si usted alcanza el máximo de \$100 para ese año. El Departamento también le mandará una carta informándole si alcanzó la cantidad máxima establecida para copagos.

Si usted es elegible para el Medicaid porque ha estado gastando parte de sus ingresos en servicios médicos, guarde sus recibos de copagos. Los copagos que usted incurra serán contados hacia su requisito de ingreso/recursos excesivos (spenddown or overage) en el siguiente mes.

USTED NO TIENE QUE PAGAR EL COPAGO SI:

1. Carece de recursos y se lo hace saber a su proveedor(a). Cualquier cantidad de copagos no pagada es dinero que usted aún debe al proveedor(a). En este caso el proveedor(a) puede solicitar la cantidad de copagos más tarde o enviarle una cuenta.

2. Es menor de 21 años de edad.
3. Usted está embarazada. En este caso pida a su médico que le proporcione una nota indicando que usted está embarazada. Usted puede mostrar esa nota a los otros proveedores que le pidan un copago. Esta exoneración continuará durante 2 meses después de haber finalizado su embarazo.
4. Está inscrito en un plan de cuidado administrado del Medicaid. La oficina local del departamento de servicios sociales puede informarle si usted pertenece a un plan de cuidado administrado del Medicaid; y si no pertenece, cómo puede hacerse miembro. Usted continúa siendo elegible para los servicios completos cubiertos por el Medicaid aunque usted no se inscriba en un plan de cuidado administrado. Actualmente, a usted no se le requiere inscribirse en un plan de cuidado administrado del Medicaid a menos que usted viva en ciertas áreas de Brooklyn.

En el curso de este año, beneficiarios viviendo en otras áreas de la Ciudad de Nueva York y el estado puede que también tengan que inscribirse en un plan de cuidado administrado del Medicaid. El departamento de servicios sociales local le enviará una carta si a usted se le requiere participar. Si usted tiene alguna pregunta acerca de su inscripción en el plan de cuidado administrado, por favor llame al 1-800-541-2831.

5. Recibe atención o servicios de emergencia. Esta es atención que usted recibe para tratar una afección severa que implique un riesgo a su vida, o por una amenaza potencial de incapacidad que necesite atención inmediata.
6. Usted recibe servicios de planificación familiar (control de natalidad). Esto incluye medicamentos o suministros para la planificación familiar tales como píldoras anticonceptivas y condones.
7. Es residente de una Institución para Envejecientes (Nursing Facility) o de una Institución de Cuidado Intermedio para Incapacitados del Desarrollo (Intermediate Care Facility for the Developmentally Disabled ICF/DD).
8. Está inscrito en un Programa Comprensivo de Administración de Casos (Comprehensive Case Management Program--CMCM) o en un Programa de Renuncia de Servicios Basados en el Hogar y la Comunidad (Home and Community Based Services Waiver Program--HCBS). Estos programas están vinculados con la Oficina de Salud Mental (Office of Mental Health--OMH) o la Oficina para el Retraso Mental e Incapacidades del Desarrollo (Office of Mental Retardation and Developmental Disabilities--OMRDD). Si usted está en cualquiera de estos programas tendrá un encargado(a) de caso. Este encargado(a) podrá ayudarle si usted tiene alguna pregunta.

9. Es residente de una institución residencial basada en la comunidad que tenga licencia de la Oficina de Salud Mental o de la Oficina para el Retraso Mental e Incapacidades del Desarrollo y no esté exento(a) por estar recibiendo los servicios de CMCM o HCBS. Un miembro del personal de su residencia le dará una carta que usted puede mostrar a sus proveedores para que no tenga que pagar el copago.
10. Usted alcanzó los \$100.00 del máximo anual establecido para copagos.

RECUERDE: NINGUN PROVEEDOR(A) PUEDE NEGARSE A PRESTARLE SERVICIOS O A SUMINISTRARLE MEDICAMENTOS O ARTICULOS MEDICOS DEBIDO A QUE USTED NO TENGA MEDIOS PARA SATISFACER LOS COPAGOS REQUERIDOS. INFORMELE ESTO A SU PROVEEDOR(A).