Kentucky Medicaid Copay Policy Update for Providers

Beginning on January 1, 2019, all Managed Care Organizations (MCOs) and providers will be required to charge copays for specific non-preventative services given to some Kentucky Medicaid beneficiaries.

Note: This copay policy will begin on January 1, 2019, whether or not the Kentucky HEALTH program has been implemented.

Frequently Asked Questions (FAQs)

These FAQs refer to the policy that takes effect January 1, 2019

1. **How will providers know if a beneficiary has a copay?**
   Providers should check the Copay Indicator and whether someone has met their cost sharing limit on KYHealthNet (http://www.kymmis.com/kymmis/index.aspx) to see if they need to collect a copay. If the beneficiary is subject to copays **and** has not met their cost sharing limit for the quarter, the provider should collect a copay. Please see pages 3 and 4 of the **Managed Care Copayment FAQ & Quick Reference Guide for Providers** for more information and detailed screenshots showing how to check these indicators.

   Note: If the beneficiary has reached their cost sharing limit for the quarter, the provider must waive the copay. In these instances, the provider will be fully reimbursed for the service.

2. **Are any services exempt from copays?**
   Exemptions may apply, but are not limited, to:
   - Emergency services
   - Some family planning services
   - Preventive services

   Providers should reach out to the MCO for the specific codes.

3. **Are any beneficiaries exempt from copays?**
   Exemptions may apply, but are not limited, to:
   - Foster children
   - Children enrolled in Medicaid
   - Pregnant women (includes 60-day period after pregnancy ends)
   - Kentucky Medicaid beneficiaries who have reached their cost share limit for the quarter
   - Individuals receiving hospice care

   Note: Kentucky Medicaid beneficiaries receiving healthcare services through the Fee-for-Service model have already been paying copays. The policy taking effect on January 1, 2019 is applying that existing copay structure to all Kentucky Medicaid beneficiaries.

More FAQs

Frequently Asked Questions (FAQs) for Providers

These FAQs refer to the policy that takes effect January 1, 2019

4. **How will providers know which services require copays?**
   Please see following pages of this Update or page 5 of the **Managed Care Copayment FAQ & Quick Reference Guide for Providers Document** for Services and Items Requiring a Copay.

5. **If a Medicaid beneficiary receives more than one service in one day, will they have multiple copays?**
   Copays are paid per visit. A visit is defined as an encounter or series of encounters that are performed on the same date of service at the same entity (including telehealth services).

6. **Can a provider refuse to see a Medicaid beneficiary if he/she does not pay the copay?**
   If the beneficiary's income is at or below 100% Federal Poverty Level (FPL), they cannot be refused services. If the beneficiary's income is over 100% FPL and they do not pay the copay, 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.***

7. **How will providers know if a beneficiary is under or over 100% Federal Poverty Level (FPL)?**
   Providers should check KYHealthNet to see whether a beneficiary is under or over 100% FPL. Please refer to page 6 of the **Managed Care Copayment FAQ & Quick Reference Guide for Providers** for more information and detailed screenshots.

8. **How will providers know if a beneficiary is part of one of the exempt groups?**
   Providers should check KYHealthNet to see whether a beneficiary is exempt from copays. Please see page 7 of the **Managed Care Copayment FAQ & Quick Reference Guide for Providers** for more information and detailed screenshots.

If you have questions, please contact the appropriate MCO.

aetna	Anthem BlueCross	Humana / CareSource	PASSPORT HEALTH PLAN	WellCare
1-855-300-5528	1-855-690-7784	1-855-852-7005	1-800-578-0603	1-877-389-9457

Services and Items Requiring a Copay

Exemptions may apply, but are not limited, to:

- Foster children
- Children enrolled in Medicaid
- Individuals receiving hospice care
- Pregnant women (includes 60-day period after pregnancy ends)
- Beneficiaries who have reached their cost share limit for the quarter

Providers should reach out to the MCO for specific codes.

Service or Item	Copay	Parameters / Definition
Preferred and non-preferred generic drug	$1.00	• Applies to all generic drugs
Brand name preferred over generic equivalent	$1.00	• Applies only to brand name drugs that are preferred over generic
Brand name drugs	$4.00	• Applies to all other brand name drugs
Chiropractor	$3.00	• Applies to all services submitted by a chiropractor
Dental	$3.00	• Applies to all services submitted on an ADA-1500
Podiatry	$3.00	• Applies to all services submitted by a podiatrist
Optometry	$3.00	• Applies to all services submitted by optometrists
General ophthalmological services	$3.00	• Applies to all services submitted by ophthalmologists • Applies to ophthalmology codes submitted by physicians and physician groups
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	• Applies to claims containing an office visit evaluation and management (E&M) procedure code and performed in an office setting • Certain diagnostic, allergy-related, and preventive diagnoses are excluded from copay collection • Applies to services performed by a behavioral health provider
Visit to a rural health clinic, primary care center, or federally qualified health center	$3.00	• Applies to claims submitted by a rural health clinic, primary care center, or federally qualified health center which contain an office visit E&M code and were performed in an office, FQHC, or RHC place of service
Outpatient surgery (ambulatory surgical care)	$4.00	• Applies to outpatient institutional claims submitted by a hospital and claims submitted by an Ambulatory Surgery Center. • Hospital claims with an E.R. revenue code (450,456) are exempt from the outpatient hospital copay • Applies to all services submitted by an ambulatory surgical center

Services and Items Requiring a Copay

See previous page for exemptions!

Service or Item	Copay	Parameters / Definition
Emergency room visit for a non-emergency service	$8.00	• Applies to non-emergency services submitted using emergency room place of service and/or revenue codes
All inpatient hospital admission	$50.00	• Applies to admissions occurring in an acute care or rehabilitation Distinct Part Unit (DPU) setting • Limited to one copay per admission
Mental health or substance abuse inpatient	$50.00	• Applies to admissions occurring in a psychiatric hospital or psychiatric DPU setting • Limited to one copay per admission
Physical therapy	$3.00	• Applies to all services submitted by Physical Therapists • Applies to physical therapy HCPCS and Revenue codes submitted by non-excluded providers
Speech therapy	$3.00	• Applies to all services submitted by Speech Therapists • Applies to speech therapy HCPCS and Revenue codes submitted by non-excluded providers
Occupational therapy	$3.00	• Applies to all services submitted by Occupational Therapists • Applies to occupational therapy HCPCS and Revenue codes submitted by non-excluded providers (see bottom of next page for list of excluded providers)
Durable Medical equipment	$4.00	• Applies to non-preventive services submitted by DME Suppliers • Excluded preventive services: A4281 – A4286 and E0602 – E0604
Laboratory, diagnostic, or x-ray services	$3.00	• Applies to laboratory, diagnostic, and x-ray HCPCS and Revenue codes submitted by non-excluded providers • If a claim includes both laboratory, diagnostic, or x-ray services in conjunction with physician office services, only one copay applies • Laboratory, diagnostic, or x-ray services which are preventive (billed with modifier 33) are not subject to copay

If you have questions, please contact the appropriate MCO.

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