DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES
Statutory Authority: 31 Delaware Code, Section 512 (31 Del.C. §512)

FINAL

Client Cost Sharing for Pharmaceutical Services

ORDER

Nature Of The Proceedings

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Title XIX Medicaid State Plan and the Division of Social Services Manual (DSSM) to establish the provisions relating to imposing and collecting co-payments for pharmaceutical services from Medicaid/Medical Assistance clients. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the November 2004 *Delaware Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by November 30, 2004 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

Summary Of The Pharmacy Services Co-payment Policy

Title of Notice:

Medicaid/Medical Assistance Client Cost Sharing

Overview:

42 USC 1396a(a)(14) permits state Medicaid programs to require certain clients to share some of the costs of Medicaid by imposing enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. The Delaware Medicaid/Medical Assistance Program (DMAP) exercises this option to impose a co-payment for prescription drugs for Medicaid clients. Having elected to impose this co-payment, DMAP must comply with the specific provisions of 42 U.S.C. 1396o, 42 CFR §§447.15, 447.21, 447.53, 447.54, 447.55 and, 447.57.

Summary of Pharmacy Services Co-Payment Policy

This notice is being given to provide information of public interest with respect to the intent of DSS to amend the Division of Social Services Manual (DSSM) and to submit to the Centers for Medicare and Medicaid Services (CMS) an amendment to the Title XIX Medicaid State Plan to establish and implement co-payments for pharmacy services. The following provisions of this amendment shall be implemented on January 10, 2005:

- All clients, other than those specifically excluded, are liable for sharing the cost of Medicaid covered prescription drugs. Medicaid clients are required to pay a specific pharmacy co-pay amount for each initial and refilled prescription and over-the-counter drug filled at a pharmacy participating in the Medicaid program.
- In accordance with 42 CFR §447.54, the pharmacy co-pay amount is based on the Medicaid fee for the drug being dispensed. The co-pay amounts imposed are as follows:

Medicaid Fee	Co-Pay Amount
$10.00 or less	$ .50
$10.01-$25.00	$1.00
$25.01-$50.00	$2.00
$50.01 or more	$3.00

- Cumulative Maximum [42 CFR §447.54(d)]. Not applicable, there is no maximum.

- In accordance with Social Security Act §1916 and 42 CFR §447.53, co-payments are not imposed upon categorically needy individuals for the following:
  - Services furnished to individuals under 21 years of age;
  - Services furnished to pregnant women; including postpartum care;
  - Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution;
  - Emergency services;
  - Family Planning services and supplies; and,
  - Services furnished to individuals receiving hospice care.
- The pharmacy will be advised via the Point-of-Sale System regarding the client's liability for the drug co-pay and the amount of the co-pay. When a client advises a pharmacy of an inability to pay the applicable co-pay amount at the time the prescription is filled, the pharmacy cannot refuse to fill the prescription and must dispense the drug as prescribed [42 CFR §447.53(e)].
- The client will remain liable for reimbursement of the co-pay amount and will be responsible for paying the pharmacy when financially able.
- Medicaid will not pay the co-pay amount to the pharmacy where a client declares an inability to pay. Provider payment will continue to be that sum which is the Medicaid fee minus the applicable client co-pay amount.

The proposed amendment applies to Medicaid clients and shall be implemented on January 10, 2005.

The proposed cost sharing requirements are subject to approval by the Centers for Medicare and Medicaid Services (CMS)

Summary Of Comments Received With Agency Response and Explanation Of Any Change(S)

DSS received comments from the following organizations: the Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD).

A summary of all the comments and agency response follows:

- In §14960.2 may wish to reconsider the language since “under the long term care nursing” is not a paragon of clarity. Does DSS intend to exempt all waiver participants from the co-pay requirement or does DSS intend to exempt actual nursing home residents?
- In §14960.2 may wish to expand the list of exempt individuals to include GA recipients.

Agency Response: This was a publication formatting problem. Under 14960.2 Exclusions from Co-payment Requirement, the list should read from “a” to “f”, not “h”. What is listed under “d” is actually a continuation of “c”. In this case, letters were dropped when the word document was imported. The final order regulation shows the correct text. DSS intends to exempt actual nursing home residents. GA and waiver participants are not exempt from the co-pay requirement.

- The proposed effective date (January 10, 2005) may leave inadequate time to advise affected beneficiaries who may need to adjust budgets, etc.

Agency Response: DSS expects to notify affected beneficiaries prior to implementation.

- DSS notes that it plans to advise pharmacies of the prohibition of service denial based on inability to pay. GACEC and SCPD respectfully requests copies of the pertinent section of the provider manual, the description in the provider newsletter, and the proposed letter to be sent to beneficiaries to review content.

Agency Response: The requested information will be made available once finalized.

- The proposed regulation undermines the Olmstead implementation because persons in institutions are exempt from the co-pays while person in the community must pay them.

Agency Response: Federal regulations require states to exempt persons in institutions.

- The co-pays are essentially nuisance payments hardly worth the cost of collection.

Agency Response: Co-pays have been implemented and are working in many other states.

- The state should adopt a "cumulative maximum co-pay" for high pharmacy users [42 CFR §447.54(d)].

Agency Response: At present, the policy will remain as is.

Findings Of Fact:

The Department finds that the proposed changes as set forth in the November 2004 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to establish the provisions relating to imposing and collecting co-payments for pharmaceutical services from Medicaid/Medical Assistance clients is adopted and shall be final effective January 10, 2005.

Vincent P. Meconi, Secretary, DHSS
Date of Signature 12.15.2004

DSS FINAL ORDER REGULATION #04-31a

Revision: **OMB No.: 0938-**

State/Territory: DELAWARE

Citation **42 CFR 447.51 through 447.58**	4.18 (a)	Recipient Cost Sharing and Similar Charges Unless a waiver under 42 CFR 431.55(g) applies deductibles, coinsurance rates, and co payments do not exceed the maximum allowable charges under 42 CFR 447.54.
1916 (a) and (b) of the Act	(b)	Except as specified in items 4.18 (b) (4), (5) and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905 (p) (1) of the Act) under the plan: (1) No enrollment fee, premium, or similar charge is imposed under the plan. (2) No deductible, coinsurance, co-payment, or similar charge is imposed under the plan for the following: (i) Services to individuals under age 18, or under-- Age 19 Age 20 **X** **Age 21**

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation 4.18 (b) (2) (Continued)

42 CFR 447.51 through 447.58

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).

(vi) Family planning

services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.

Revision: **OMB No.: 0938-**

State/Territory: DELAWARE

Citation 4.18(b) (Continued)

42 CFR 447.51 through 447.48

(3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, co-payment, or similar charges are imposed for services that are not excluded from such charges under item (b) (2) above.

Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

18 or older
19 or older
20 or older
X 21 or older

Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age

Citation 4.18 (b) (3) (Continued)

42 CFR 447.51 through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries**,** **ATTACHMENT 4.18-A** specifies the:

A. Service(s) for which a charge(s) is applied;

B. Nature of the charge imposed on each service;

C. Amount(s) of and basis for determining the charge(s);

D. Method used to collect the charge(s);

E. Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

F. Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b);and

G. Cumulative maximum that

applies to all deductible, coinsurance or co-payment charges imposed on a specified time period.

X Not applicable. There is no maximum.

Citation			
1916 (c) of the Act	4.18 (b) (4)	☐	A monthly premium is imposed on pregnant women and infants who are covered under section 1902 (a)(10)(A)(ii) (IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916 (c) of the Act are met **ATTACHMENT 4.18-D** specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902 (a) (52) and 1925 (b) of the Act	4.18 (b) (5)	☐	For families receiving extended benefits during a second 6-month period section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925 (b) (4) and (5) of the Act.
1916 (d) of the Act	4.18 (b) (6)	☐	A monthly premium, set on a sliding scale, imposed on

qualified disabled and working individuals who are covered under section 1902 (a) (10) (E) (ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved.
The requirements of section 1916 (d) of the Act are met.
ATTACHMENT4.18-E
Specifies the methods and standards the State uses for determining the premium.

DSS FINAL ORDER REGULATION #04-31c

Division of Social Services Manual (DSSM)

14960 Cost Sharing

Section 1902(a)(14) of the Social Security Act permits states to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges.

14960.1 Co-Payment Requirement

Effective January 10, 2005, a nominal co-payment will be imposed for generic and brand name prescription drugs as well as over-the-counter drugs prescribed by a practitioner.

The co-payment is based upon the cost of the drug as follows:

Medicaid Payment for the Drug	Co-payment
$10.00 or less	$.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The co-payment is imposed for each drug that is prescribed and dispensed.

14960.2 Exclusions from Co-payment Requirement
The following individuals and services are excluded from the co-payment requirement:

a. individuals under age 21
b. pregnant women, including the postpartum period
c. individuals eligible under the long term care nursing facility group or the acute care hospital group
d. emergency services
e. family planning services and supplies
f. hospice services

14960.3 Inability to Pay

The pharmacy provider may not refuse to dispense the prescription(s) subject to the co-payment requirement because of the individual's inability to pay the co-payment amount. When a recipient indicates that he or she is unable to meet the co-payment requirement, the pharmacy provider must dispense the prescription(s) as written. Medicaid reimbursement for the prescription(s) will be the Medicaid fee minus the applicable co-payment amount.

The recipient remains liable for the co-payment amount and is responsible for paying the pharmacy when financially able. The pharmacy provider is permitted to pursue reimbursement of the co-payment amount from the recipient.