12VAC30-20-150. Copayments and deductibles for categorically needy and QMBs for services other than under 42 CFR 447.53.

A. The following charges are imposed on the categorically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR447.53.

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions: Generic Brand-Name	 -0- -0-	 -0- -0-	 $1.00 $2.00	State's average per generic script of $18 is used as payment basis. State's average per brand-name script of $70 is used as payment basis
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for categorically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. State policy does not provide for cumulative maximums on charges.

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

G. Definitions. For the purposes of this regulation, "generic drug" shall be defined as any multiple source product meeting the criteria set forth in 42 CFR § 447.332 and § 1927(e) of the Social Security Act, as amended by OBRA '93. Such "generic drug" must have a current

Federal Upper Limit (FUL) payment level defined by the Health Care Financing Administration.

H. "Brand name" pharmaceutical products mean

1. Any drug product not meeting the definition of a "generic drug" as previously stated, or

2. Any drug product for which the prescriber, through the use of the notation "brand necessary" on the prescription, does not allow substitution.

CERTIFIED:

/s/ July 19, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services

12VAC30-20-160. Copayments and deductibles for medically needy and QMBs for services other than under 42 CFR 447.53.

A. The following charges are imposed on the medically needy and Qualified Medicare Beneficiaries for services other than those provided under 42 CFR 447.53.

Service	Type Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay	
Inpatient Hospital	$100.00	-0-	-0-	State's average daily payment of $594 is used as basis.
Outpatient Hospital Clinic	-0-	-0-	$3.00	State's average payment of $136 is used as basis.
Clinic Visit	-0-	-0-	$1.00	State's average payment of $29 is used as basis.
Physician Office Visit	-0-	-0-	$1.00	State's average payment of $23 is used as basis.
Eye Examination	-0-	-0-	$1.00	State's payment of $30 is used as basis.
Prescriptions: Generic Brand-Name	-0- -0-	-0- -0-	$1.00 $2.00	State's average per generic script of $18 is used as payment basis. State's average per brand-name script of $70 is used as payment basis
Home Health Visit	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Other Physician Service	-0-	-0-	$3.00	State's average payment of $56 is used as basis.
Rehab Therapy Services (PT, OT, Sp/Lang.)	-0-	-0-	$3.00	State's average payment $78 is used as basis.

*NOTE: The applicability of copays to emergency services is discussed further in this section.

B. The method used to collect cost sharing charges for medically needy individuals requires that providers be responsible for collecting the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers will, based on information available to them, make a determination of the recipient's ability to pay the copayment. In the absence of knowledge or indications to the contrary, providers may accept the recipient's assertion that he or she is unable to pay the required copayment.

Recipients have been notified that inability to meet a copayment at a particular time does not relieve them of that responsibility.

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR § 447.53(b) are described below:

The application and exclusion of cost sharing is administered through the program's MMIS. Documentation of the certified computer system delineates, for each type of provider invoice used, protected eligible groups, protected services and applicable eligible groups and services.

Providers have been informed about: copay exclusions; applicable services and amounts; prohibition of service denial if recipient is unable to meet cost-sharing changes.

E. State policy does not provide for cumulative maximums.

F. Emergency Services. No recipient copayment shall be collected for the following services:

1. Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the patient's health in serious jeopardy;

b. Serious impairment to bodily functions; or

c. Serious dysfunction of any bodily organ or part; and

2. All services delivered in emergency rooms.

G. Definitions. For the purposes of this regulation, "generic drug" shall be defined as any multiple source product meeting the criteria set forth in 42 CFR § 447.332 and § 1927(e) of the Social Security Act, as amended by OBRA '93. Such "generic drug" must have a current Federal Upper Limit (FUL) payment level defined by the Health Care Financing Administration.

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H. "Brand name" pharmaceutical products mean

1. Any drug product not meeting the definition of a "generic drug" as previously stated, or

2. Any drug product for which the prescriber, through the use of the notation "brand necessary" on the prescription, does not allow substitution.

CERTIFIED:

July 19, 2000
Date

/s/ Dennis G. Smith
Dennis G. Smith, Director
Dept. of Medical Assistance Services