§111. Copayment

A. Payment Schedule

1. A copayment requirement in the Pharmacy Program is based on the following payment schedule.

Calculated State Payment	Copayment
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

2. The pharmacy provider shall collect a copayment from the Medicaid recipient for each drug dispensed and covered by Medicaid. The following pharmacy services are exempt from the copayment requirements:

a. services furnished to pregnant women;

b. emergency services;

c. family planning services; and

d. preventive medications as designated by the U.S. Preventive Services Task Force's A and B recommendations.

3. The following population groups are exempt from copayment requirements:

a. individuals under the age of 21;

b. individuals residing in a long-term care facility;

c. individuals receiving hospice care;

d. Native Americans and Alaskan Eskimos;

e. women whose basis for Medicaid eligibility is breast or cervical cancer; and

f. home and community-based services waiver recipients.

B. In accordance with federal regulations, the following provisions apply.

1. The provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. However, this service statement does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

2. Providers shall not waive the recipient copayment liability.

3. Departmental monitoring and auditing will be conducted to determine provider compliance.

4. Violators of this Section maybe subject to a penalty, including but not limited to, termination from the Medicaid Program.

5. The state will ensure Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a monthly basis.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, LR 32:1055 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1181 (June 2017), LR 43:1553 (August 2017), LR 46:34 (January 2020).

§ 119. Maximum Quantity

A. For all prescriptions, the maximum quantity payable shall be a month's supply or 100 unit doses, whichever is greater. The quantity billed shall be that prescribed, unless it exceeds the maximum quantity payable in which case the maximum quantity payable shall be filled.

B. When maintenance drugs are prescribed and dispensed for chronic illnesses they shall be in quantities sufficient to effect economy in dispensing and yet be medically sound. Maintenance type drugs should be prescribed and dispensed in a month's supply after the initial fill.

C. For patients in nursing homes, the pharmacist shall bill for a minimum of a month's supply of medication unless the treating physician specifies a smaller quantity for a special medical reason.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1056 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1182 (June 2017), LR 46:34 (January 2020).