New Mexico Human Services Department
Medicaid Co-Payment Proposal & Notice of Opportunity to Comment

The New Mexico Human Services Department (HSD) is proposing to implement new or revised co-payment requirements for certain Medicaid recipients effective October 1, 2017, as described in this notice. The 2016 General Appropriations Act directed the Department to “pursue necessary federal authority to include additional cost-sharing require-ments for recipients of Medicaid services, including co-payments for certain services.”

HSD has developed a co-payment proposal for Medicaid recipients that will meet the requirements of the 2016 General Appropriations Act, while ensuring that cost-sharing responsibilities of Medicaid recipients are reasonable.

Co-payments are amounts that Medicaid recipients pay directly to a provider for a service, visit, or item. Co-payments are to be charged at the time of service or receipt of the item. Certain services and populations are exempt from any co-payments, which means that no mandatory co-payments will be charged for those services or populations. These exemptions are explained and detailed in this notice.

Some Medicaid co-payments will apply only to certain categories of eligibility and to individuals above a certain income level. Other Medicaid co-payments will apply to most categories of eligibility and at most income levels. All proposed co-payments are described in this notice and in the proposed rules posted at:

http://www.hsd.state.nm.us/LookingForInformation/registers.aspx, and


Proposed co-payments that will apply only to Other Adult Group (also referred to as the Medicaid Expansion or Category of Eligibility 100) recipients with income above 100% of the federal poverty level (FPL); Working Disabled Individuals (WDI); and the Children’s Health Insurance Program (CHIP) include:

- **Outpatient Office Visits - $5/visit.** The co-payment applies to non-preventive care outpatient office and clinic visits or hospital outpatient department visits for physician or other practitioner services, dental visits, urgent care visits, and outpatient professional therapies. Only one co-payment is allowed per visit or session. Behavioral health outpatient visits, preventive care visits, prenatal visits/pregnant recipients, and laboratory, radiology and diagnostic laboratory tests and measurements ordered by a practitioner are exempt from any co-payment. Services that are protected under state minor consent laws are also exempt.

- **Inpatient Hospital Stays - $ 50/entire stay.** Only one co-payment is allowed per inpatient stay, including when a patient is transferred from one hospital to another hospital. Inpatient psychiatric hospital stays and labor/delivery inpatient obstetric stays are exempt from any co-payment.
- **Outpatient Surgeries - $50/procedure** - Applies to outpatient surgeries performed in office settings, outpatient facilities and ambulatory surgical centers that are performed separately and distinct from an office or clinic outpatient visit. The co-payment applies only to the primary surgical procedure performed. Services that are protected under state minor consent laws are exempt from any co-payment.

- **Prescription Drugs, medical equipment, and medical supplies - $2/prescription, item, or monthly rental.** The co-payment is not charged if the higher co-payment for non-preferred prescription drugs is applied, as described below. Contraceptives and family planning supplies are exempt from the co-payment. Psychotropic drug items are also exempt.

Proposed co-payments that will apply to most Medicaid categories of eligibility and at most income levels include:

- **Non-Preferred Prescription Drugs - $8/prescription.** Applies to Other Adult Group, WDI, CHIP, and most other Medicaid beneficiaries, unless described as exempt below. Psychotropic drug items are exempt. Contraceptives and family planning supplies are also exempt.

- **Non-Emergency use of the Hospital Emergency Department - $8/visit** for Other Adult Group, WDI, CHIP, and most other Medicaid beneficiaries, unless described as exempt below. Screening is required in accordance with 42 CFR §489.24, and all requirements outlined in the proposed rules must be met to assess co-payment.

Co-payments are not to be charged for the following exempt individuals:
- Native Americans who are active or previous users of the Indian Health Service (IHS), tribal 638 health programs, or urban Indian health programs
- Persons who are receiving care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)
- Persons who are enrolled only in the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLIMB) or Qualified Individuals program
- Persons who are covered only under the Medicaid Family Planning program
- Persons who are enrolled in the Program of All Inclusive Care for the Elderly (PACE)
- Persons who are enrolled in the 1915(c) Developmentally Disabled waiver program
- Persons who are receiving hospice care

Co-payments are not to be charged for the following exempt services:
- Community benefit services, nursing facility stays, or home and community based (HCBS) waiver services
- Hospice care services
- Family planning services, procedures, surgeries, prescription drug items, supplies, and devices
- Pregnancy-related health care, including tobacco cessation treatment for pregnant women, prenatal drug items, and postnatal care
- Laboratory, radiology, and diagnostic laboratory tests and measurements ordered by a practitioner
- Emergency services
- Preventive services, including well-child visits, immunizations, and periodic health exams; preventive dental cleanings and exams; and covered routine vision services
- Services provided to minors that are protected under minor consent laws
- Behavioral health outpatient visits, inpatient hospital stays, and psychotropic drug items
- Labor and delivery inpatient obstetric stays
- Services rendered to treat provider preventable conditions
- Services rendered before an individuals’ determination of Medicaid eligibility, even if covered retroactively
- Services rendered under the Medicaid School-Based Services (MSBS) program
- Services rendered under agreement with the Department of Health (DOH) Children’s Medical Services program
- Services covered by Medicare or a Medicare Advantage plan, or following payment by another primary insurer when the Medicaid payment is made toward a deductible, co-insurance, or co-payment determined by the primary payer

The State proposes allowing providers to require individuals to pay co-payments as a condition for receiving items or services when the household has income above 100% of the federal poverty level (FPL). Providers may not deny services to a beneficiary on account of the beneficiary’s inability to pay the co-payment when the household has income at or below 100% FPL. Before charging a co-payment, providers must confirm the beneficiary’s eligibility information by checking the beneficiary’s managed care organization (MCO) member card or information in the Medicaid provider portal to verify if a co-payment applies. Providers may not charge co-payments to exempt individuals or for any exempt items or services, as described above.

The total amount of co-payments paid by a Medicaid beneficiary household cannot exceed five percent of the family’s total household income during a calendar quarter (January-March, April-June, July-September, and October-December). If a household reaches the five percent limit, then no more co-payments will be charged during the remainder of that quarter. The contracted MCOs are required to track co-payments and to notify households of their co-payment responsibilities and accrued co-payments.

HSD estimates that the total financial impact of the proposed co-payment proposal will result in a savings of approximately $500,000 to $1.5 million in state general funds to the Department and approximately $4,000,000 in matching federal funds, for total savings of $4.5 to $5.5 million.

These proposed rules will be contained in 8.302.2 and 8.308.14 NMAC. The register and proposed rule language are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformationregisters.aspx and http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx.

Medicaid providers, Medicaid recipients, and other interested parties are invited to make comments on this co-payment proposal.

A public hearing to receive testimony on these proposed rules will be held in the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road Santa Fe on July 14, 2017 at 9:00 a.m. Mountain Daylight Time (MDT).

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Medical Assistance Division in Santa Fe at 505-827-6252. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

A written copy of these proposed documents may be requested by contacting the HSD Medical Assistance Division (HSD/MAD) in Santa Fe at (505) 827-6252.
Recorded comments may be left by calling (505) 827-1337.

Electronic comments may be submitted to madrules@state.nm.us.

Interested persons may address written or recorded comments to:

Human Services Department  
Office of the Secretary  
ATTN: Medical Assistance Division Public Comments  
P.O. Box 2348  
Santa Fe, New Mexico 87504-2348

Written mail, electronic mail and recorded comments must be received no later than 5 p.m. MDT on July 14, 2017. Written comments and recorded comments will be given the same consideration as oral testimony made at the public hearing.