1. The following charges are imposed on the categorically needy

Service	Copayment Amount	Population Subject to Copay
Pharmacy drug items	$2	Children's Health Insurance Plan (CHIP) Recipients
	$5	Working Disabled Individuals (WDI)
	$3	Alternative Benefit Plan Recipients (ABP) 101% - 138% FPL
Outpatient Practitioner Visit	$5	CHIP
	$7	WDI
	$8	ABP 101% - 138% FPL
Outpatient emergency room	$15	CHIP
	$20	WDI
Inpatient admission	$25	CHIP
	$30	WDI
	$25	ABP 101% - 138% FPL
Non-Preferred Drugs	$5	CHIP
	$8	WDI
	$3	Standard Medicaid recipients and ABP-exempt recipients
	$3	ABP FPL 100% or below
	$8	ABP 101% - 138% FPL
Non Emergent Use of the Emergency Department	$50	CHIP
	$28	WDI
	$8	Standard Medicaid recipients -150% FPL or below and ABP-exempt recipients 138% FPL
	$50	Standard Medicaid recipients - greater than 150% FPL
	$8	ABP FPL at 100% or below and ABP 101% - 138% FPL

Certain individuals and services are excluded from copayments in compliance with 42 CFR § 447.56 *Limitations on premiums and cost sharing*.

Copayments are imposed at amounts that do not exceed the maximum allowable amounts under 42 CFR 447.52, *Cost sharing,* 447.53 *Cost sharing for drugs* and 447.54 *Cost sharing for services furnished in a hospital emergency department.* The Medicaid Assistance Division (MAD) performs periodic post-payment calculations and reviews of claims data to ensure that the limits are not exceeded.

Limitations on cost-sharing are:

1. Only one co-payment is applied for a service. If more than one co-payment does apply, the only co-payment applicable is the higher of the co-payments.
2. The co-payment for a non-preferred drug does not apply when the prescriber determines that the alternative drug on the preferred drug list will be less effective or have greater adverse reactions than the non-preferred drug; or when the drug is a psychotropic drug item.
3. The co-payment for inpatient hospital admission is not applied when the hospital is receiving the recipient as a transfer from another hospital or when the recipient is admitted through the emergency room.
4. The following is a list of exemptions to cost-sharing:
    a. Native Americans
    b. Services rendered by an Indian Health Services (IHS), 638 facility or urban Indian facility
    c. Emergency services
    d. Family planning services, drugs, procedures, supplies and devices
    e. Hospice patients
    f. Medicare Crossover claims
    g. Pregnant women
    h. Prenatal and postpartum care and deliveries, and prenatal drug items
    i. Mental/behavioral health and substance abuse services, including psychotropic drug items
    j. Preventive services
    k. Provider preventable conditions
    l. Recipients who have reached the family unit out-of-pocket (OOP) maximum

The copayment is collected by the provider at the time the service is provided.

A provider is not able to refuse services to the recipient when the recipient is unable to pay the copayment at the time of service. If the recipient is unable to pay the copayment when the service is provided, the provider may bill the recipient for the amount of the copayment or attempt to collect it at a future visit.

MAD ensures that individuals exempt from cost sharing are not charged by the following methods:

1. MAD provides notices to Medicaid recipients of general information regarding the imposition of co-payments, including specific amounts and groups of individuals who are excluded. An individual who is unable to pay the copayment may identify him or herself by self-declaration to the provider.
2. MAD providers are informed of general information regarding the imposition of co-payments, including the specific co-payment amounts and groups of individuals who are excluded through both formal and informal regulations and notices.
3. MAD providers are also informed to review their remittance advice (RA) documents for copayment calculations. If a copayment amount was erroneously collected from a recipient; that is, it was collected but the copayment amount was not deducted from the provider's payment as shown on their RA because the copayment did not actually apply for that service or recipient, then the provider must refund the copayment collected.
4. The New Mexico Medicaid Management Information System (MMIS) identifies certain groups of exempt individuals in the following ways:
   a. Native Americans – by race code
   b. Services rendered by an Indian Health Service (IHS), 638 facility, or Urban Indian Facility – by provider type and / or IHS indicator
   c. Family planning services, procedures, drugs, supplies, and devices – by family planning – related indicator
   d. Preventive services regardless of age – by system lists of procedure codes, diagnoses and combinations of procedure codes and diagnoses used together
   e. Provider preventable conditions – by diagnosis code and / or modifier
   f. Prenatal & postpartum care and deliveries, and prenatal drug items – by diagnosis and / or procedure code and/or by drug therapeutic class
   g. Psychotropic drug items – by National Drug Code (NDC) and drug therapeutic class

h. Recipients in foster care, adoption programs, or institutional categories of eligibility – by category of eligibility

MAD ensures that providers are able to identify when a copayment applies to an item or service, when an individual or service is exempt, and other requirements and information related to cost-sharing by the following methods:

a. MAD providers are informed through both formal and informal regulations and notices.
b. MAD providers may inquire about the cost sharing policy by calling the New Mexico Medicaid fiscal agent's provider help desk.
c. MAD providers can access the applicable cost-sharing amounts on the provider web portal maintained by MAD's fiscal agent.
d. MAD providers can also access applicable cost-sharing amounts through the Medicaid Eligibility Verification System (MEVS).

Certain steps must be taken in order for the copayment for a non-emergent use of the emergency room to be applied, in compliance with § 447.54 *Cost sharing for services furnished in a hospital emergency department*. Ultimately, the hospital will determine and report whether a recipient used the emergency room for a non-emergent service. MAD will then compare the reported non-emergent service against a list of pre-determined procedure and / or diagnosis codes considered to be emergencies, in order to assure the co-payment has been correctly applied.

The New Mexico Medicaid eligibility system, ASPEN, calculates the aggregate out-of-pocket maximum (OOP) for each recipient and family unit. The OOP is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. ASPEN then communicates that amount to the applicable payer for each recipient and recipient family unit. The payer then knows to cap recipient payment of copayments at that amount. MAD provides each recipient, at his or her request, with information regarding co-payments that have been applied to claims for the recipient.