

NEW MEXICO MEDICAID PROGRAM COPAYMENTS (Final Version 12-10-2013)

CHIP RECIPIENT COPAYMENTS Children's Health Insurance Plan Categories of Eligibility 071, 0420, and 0421
Copayment only applies when the federal match code is 1

PHARMACY COPAYMENT:

\$ 2 per drug item - Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

PRACTITIONER SERVICES COPAYMENTS:

\$ 5 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see "hospital copayments" below. Only one copayment is applied per visit or session.

When the "visit" takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied to the professional charge, not to the facility charge.

HOSPITAL COPAYMENTS:

When the copayment is applied to an inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

\$ 15 outpatient emergency room - Does not apply if the copayment for non-emergent use of the ER is assessed.

\$ 25 inpatient admission - Not applied when the hospital receives recipient as a transfer from another hospital.

EXEMPTIONS

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. - See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8.
9. Federal match 3 for COE's 071 and COE's 420, and 421 because they are presumptively eligible children.

COPAYMENTS FOR UNNECESSARY SERVICES:

\$ 5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. - See note section on page 7, note 3.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

\$ 50 for non emergent use of ER - See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions.
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8 of note 4; and on page 9, item 12 of note 4.

WDI RECIPIENT COPAYMENTS Working Disabled Individuals

Category of eligibility: 074

PHARMACY COPAYMENT:

\$ 5 per drug item - Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

PRACTITIONER SERVICES COPAYMENTS:

\$ 7 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see "hospital copayments" below. Only one copayment is applied per visit or session.

When the "visit" takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied to the professional charge, not to the facility charge.

HOSPITAL COPAYMENT:

When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

\$ 20 outpatient emergency room - Does not apply if the copayment for unnecessary use of the ER is assessed.

\$ 30 inpatient admission - Not applied when the hospital receives recipient as a transfer from another hospital.

EXEMPTIONS

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. – See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.

COPAYMENTS FOR UNNECESSARY SERVICES:

\$ 8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. See note section on page 7, note 3.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

\$ 28 for non emergent use of ER - See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.

ABP - ALTERNATIVE BENEFIT PLAN COPAYMENTS Category of Eligibility 100 - APPLIES ONLY TO ABP RECIPIENTS WHO ARE 101% - 138% FPL

► (For ABP recipients who are at an FPL of 100% or below, or who are ABP Exempt, the only copayments that can apply are for unnecessary use of a brand name drug and unnecessary use of an ER, see page 6)

PHARMACY COPAYMENT:

\$3 per drug item Does not apply if the copayment for unnecessary brand name drug utilization is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items and some behavioral health drugs.

PRACTITIONER SERVICES COPAYMENTS:

\$8 Outpatient visit to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session.

This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service, not to any facility charge.

These practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services.

HOSPITAL COPAYMENTS

\$ 25 inpatient admission - A copayment 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.

When the copayment is applied to an inpatient service, the copayment is always applied to the hospital charge, not the professional charge.

EXEMPTIONS for ABP

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Emergency services, See note section on page 6, note 1.
4. Family planning services, drugs, procedures, supplies, and devices
5. Hospice patients
6. Medicare Cross Over claims including claims from Medicare Advantage Plans
7. Pregnant women - all services unless MAD gets approval from CMS to exempt some services as not pregnancy related; so currently all services for pregnant women are exempt.
8. Prenatal & postpartum care and deliveries, and prenatal drug items
9. Mental health (behavioral health) and substance abuse services, including psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)

COPAYMENTS FOR UNNECESSARY SERVICES:

\$8 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

See note section on page 7, note 3.

\$ 8 For non emergent use of ER
See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions
When the maximum family out of pocket expense has been reached.
See note section on page 8, item 8.

10. All preventive services
11. Provider preventable conditions
12. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.
13. Emergency services

Note: The usual ABP copayments do not apply to an ABP-exempt recipient. The only copayments that apply to the ABP exempt recipient or to an ABP recipient at 100% FPL or below are those for unnecessary use of a brand name or an ER. See page 6, other recipients.

The ABP exempt recipient is identified by having a “disability type code” on the eligibility file of ME or PH.

Emergency Services Exemption for Above ABP Copayments

- The ABP copayments do not apply when treatment is for an “exempt emergency service” as described in the Social Security Act and CFR.
- These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services.
- For additional information on this provision, see note section on page 6, note 1.

OTHER MEDICAID RECIPIENTS

Note that if the FPL is not available on January 1, 2014, use the lower copayment until the FPL is available.

Applies to:

1. **ABP recipients who have an FPL at 100% or below**
2. **ABP Exempt recipients**
3. **Other standard Medicaid recipients except for recipients in foster care, adoption programs, or institutional categories of eligibility**

These recipients who have "standard" Medicaid eligibility, so they generally do not have copayments on services. However, they can be assessed a copayment for non-emergent use of the ER or for unnecessary use of a brand name, unless they are one of the following categories of eligibility.

CATEGORIES OF ELIGIBILITY FOR WHOM THE COPAYMENTS FOR NON EMERGENT USE OF THE ER AND UNNECESSARY USE OF BRAND NAMES DO NOT APPLY:

014 foster care	047 adoption	081 institutional care
017 adoption	066 foster care	083 institutional care
037 adoption	086 foster care	084 institutional care
046 foster care		

OTHER EXEMPTIONS:

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. For psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)
5. Provider preventable conditions
6. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8, and on page 9, item 12 of note 4.

Note:

- There is no copayment for drug items other than the unnecessary use of a brand name.
- There are no payments for practitioner services, hospital services, or emergency room services other than the non emergent use of the ER.

COPAYMENTS FOR UNNECESSARY SERVICES:

\$ 3 For a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. – See note section on page 7, note 3.

FOR NON EMERGENT USE OF THE EMERGENCY ROOM -

Varies by FPL:

\$ 8 for 150% FPL or below

\$50 for greater than 150% FPL

See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare

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| | <p>Advantage Plans</p> <p>4. Provider preventable conditions
When the maximum family out of pocket expense has been reached.
See note section on page 8, item 8.</p> |
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Note 1: Alternative Benchmark Plans: Notes on the Exemption from Copayments for Emergency Services

Exempt emergency services (federal definitions): *“Emergency medical condition”* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are as follows:

- (1) Furnished by a provider that is qualified to furnish these services under this title.
- (2) Needed to evaluate or stabilize an emergency medical condition.

Provider Responsibilities:

- The MCO is responsible for setting up their process which may include requirements for the provider to identify when a copayment is exempt because the service is an emergency.

MCO Responsibilities:

- To not apply the ABP copayment to services in emergency rooms. Unless, the non-emergent use of the emergency room copayment is assessed, an emergency room service is presumed to be an emergency. Very likely, an inpatient hospital stay when the admission is through an emergency department, the inpatient hospital stay qualifies as an emergency.
- To develop their own rules and process consistent with the federal requirements. MAD can provide direction as necessary.
- To recognize when other providers report the service as exempt from the copayment because it is an emergency. In which case the MCO does not deduct the ABP copayment from the amount paid to the provider.

Note 2: Assessing a Copayment for Non-Emergent Use of the Emergency Room

Hospital Responsibilities:

- The hospital provider will determine if the recipient is using the emergency room for a non-emergent service. In making this determination, the hospital must consider the medical presentation of the recipient, age, and other factors, as well as alternatives that may be available in the community, the time of day, etc.
- The hospital must provide an appropriate level of screening to determine whether the service constitutes an emergency. Before assessing the copayment, the hospital must provide the individual with the name and contact information for an alternative provider that can provide the services in a timely manner with a lesser or no copayment (depending on the recipient's category.) If the recipient chooses to go to the alternative provider, the hospital assists with making an appointment for the recipient. Depending on the day and the time, this may include helping contact the alternative provider or providing the name(s) and phone number(s) of the providers, directions, etc. If geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.
- The hospital must tell the recipient the amount of the copayment. If the recipient agrees to go with an alternative, the copayment for non-emergent use of the ER is not assessed by the hospital.
- If the recipient wants to continue to receive emergency room services beyond that initial screening, the hospital assesses the co-payment.
- When the hospital assesses the copayment, it is reported to the MCO, and the MCO reduces the payment to the hospital by the copayment amount. If the hospital is not able to collect the copayment amount, the copayment amount should not be deducted from the hospital payment.

MCO Responsibilities:

- To recognize when the copayment has been assessed by the hospital and collected from the recipient, and only then to reduce the payment to the hospital by the copayment amount.

Note 3: Assessing a Copayment for Unnecessary Use of a Brand Name Drug

The copayment for unnecessary use of a brand name drug is applied to a brand name drug that is NOT on the PDL, with the following limitations:

- If in the prescriber's estimation, the alternative drug item available on the PDL is either less effective for treating the recipient's condition, or would have more side effects or higher potential for adverse reactions, the copayment cannot be applied. Presumably, if the MCO approved the use of a brand name drug NOT on the PDL for one of these reasons, then the copayment cannot be applied.
- If the prescriber has stated the brand is medically necessary and therefore the claim is billed with a dispense as written indicator, the copayment

cannot be applied unless the MCO ascertains the reason for the brand being medically necessary is something other than the fact that the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the recipient.

MCO Responsibilities:

- The MCO should consider how to construct a PDL in order to apply this copayment. For example, maybe only a first tier drug item is called the "PDL" while a second tier is maybe called something else, maybe "Alternatives".
- The MCO must determine the means by which a copayment on a brand name drug will not be applied when the above conditions are met.

Note 4: General Rules for all copayments

1. Native Americans are always exempt from all these copayments.
2. 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. However, the provider is still required to apply the copayment by billing the recipient or trying to collect it at a future visit.
3. Only one copayment can be charged per visit or encounter. There are no other copayments applied during an inpatient stay other than the one applied for hospital admission.
4. Except for non-emergent use of the ER, the MCO must assume the copayment applies and must deduct the applicable copayment from the claim prior to paying the provider regardless of whether the copayment was actually collected by the provider unless:
 - The recipient or service is exempt from copayment per the criteria on this chart, or
 - The service is exempt based on information from the provider (such as a service to an ABP recipient being an emergency) or
 - The recipient is exempt from the copayment because the total copayments paid by the family exceed 5% of the family's income in which case this information is communicated to the MCO.
5. For non-emergent use of the ER, the MCO should assume the copayment for the unnecessary use does not apply, unless indicated by the hospital provider that the copayment has been assessed.
6. There may be instances where the MCO may not know when the use of a brand name drug item should not be subjected to the unnecessary use of a brand name copayment. The MCO must formulate their procedures for this process.
7. Ideally, the concept of what constitutes preventive care will be standard across all MCO's, but the effort to accomplish this will have to come in the future, probably after the implementation Centennial Care. MAD will give direction as necessary. Note that this concept of "preventive care" is not necessarily the same as the list produced by CMS for the ABP plan, which is often limited by age or frequency and does not generally consider risk factors and other conditions that may make a service preventive in nature.

8. Exceeding the 5% of the family income:

In order to determine if an individual is exempt from copayment, the MCO will have to accumulate the amount of copayments for every member in the family using the case number. When those accumulated copayments reach the family out of pocket maximum expense, then all members of the family are exempt from copayments.

- Example: If John Jr. had a \$50 copayment, and Suzie Jr. had a \$50 copayment, and the family out of pocket maximum for the quarter is \$100, when little Robbie has a service and the copayment is \$5, the family out of pocket maximum for the quarter has already been met. Little Robbie doesn't have to make a copayment. In other words, it is the total amount that has been deducted from provider payments as copayments for all members of the family, not the individual, that are accumulated and compared to the family out of pocket maximum for the quarter.

Copayments for unnecessary use of brand name drugs or ER non emergency use are also included in the accumulation of the total family out of pocket maximum for the quarter.

9. When other insurance has paid for the service and the amount being paid by an MCO is toward the co-insurance and deductible, copayments are not applied.

10. Copayments are never applied to services that are considered Community Benefits under the MCO contract and rules.

11. Copayments are not applied to services that were rendered prior to eligibility being established, even though retroactive eligibility later covers the time period during which the service was rendered.

12. The MCO must track, by quarter, all co-payments applied to claims for each individual member in the household family to ensure that the family does not exceed the aggregate out-of-pocket maximum (OOP). The OOP is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

13. The MCO must report to the provider when a copayment has been applied to the provider's claim and when a copayment was not applied to the provider's claim. This is done, at a minimum, using the remittance advice, EOB, or equivalent electronic transaction. The MCO shall be responsible for assuring the provider is aware that:

- The provider shall be responsible for refunding to the member any copayments the provider collects after the eligible recipient has reached the co-payment out-of-pocket maximum (five percent of the eligible recipient's family's income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing.
- The provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider's payment whether the discrepancy occurs because of provider error or MCO error.

