Medicaid Premiums and Cost Sharing

State Name: New Mexico

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Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. Yes

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ○ Under age 21
- ◉ Other reasonable category

Description:

The intent of the Human Services Department is only to exempt Native American recipients who have received services from an IHS facility or tribal 638 facility, or who have received services that were paid by IHS delivered by a provider as a subcontractor to IHS.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. No

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ■ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ■ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ■ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ■ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ■ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ■ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(1)(x), the state uses the following procedures:
  - ☒ The state accepts self-attestation

☐ The state runs periodic claims reviews

☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document

☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☐ Other procedure

Additional description of procedures used is provided below (optional):

☒ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☒ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☒ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

The Human Services Department also allows recipients to identify themselves to providers at the time of service as being exempt form cost-sharing. Cards issued to recipients enrolled in managed care organizations also contain copayment information.

Additional description of procedures used is provided below (optional):

Payments to Providers

☑ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☑ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

Medicaid Premiums and Cost Sharing

☑ 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 quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- ◉ 5%
- ○ 4%
- ○ 3%
- ○ 2%
- ○ 1%
- ○ Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ◉ Quarterly
- ○ Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. Yes

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

☐ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.

☒ Managed care organization(s) track each family's incurred cost sharing, as follows:

Initial Notification – The MCOs send a Copay Maximum Initial notification on April 1, 2014 to all clients, that notifies the client of the quarterly copay maximum amount. The copay maximum used will be that reported on the Roster File. Even clients with $0 copay maximum are to be sent this letter. The Human Services Department (HSD) provides the content of the letter to be sent.
a. Letters are to be sent by Case Number, identifying each of the clients who share the case and thus share the same Copay Maximum amount.
b. The copay maximum is to be the amount shown on the client's records on the Enrollment Roster file who share that Case Number multiplied by 3 to represent the quarterly amount. For example, if a case number is shared by 3 clients, the quarterly copay maximum will be $300 which applies to all claims for all 3 clients in the quarter.
c. The copay maximum notification will be addressed to the Head of Household and will list all the clients who share that Case Number and thus copay max amount.

Tracking – for clients who have a copay max amount > $0, the MCO will track all copays reported on claims from all providers (subcontracted providers are required to report copays to the MCOs) and accumulate the amounts paid toward the quarterly max for that 'household'. This amount may be updated as claims adjustments/ voids occur.
For clients who have a copay max amount = $0, this means the client has no copay maximum amount.

Quarterly Summary of Copay Max – At least quarterly, and more often if a client reaches their copay maximum

before the end of a quarter, the MCO will report the client's accumulation of copays towards their maximum, including the accumulation to date for the most recent quarter passed and previous two quarters. Because of claims lag, it is necessary to show the amounts of copay accumulated for two prior quarters along with what is reported for the most recent quarter

If the client meets their maximum copay prior to the end of the quarter, the MCO will report this to the client immediately rather than wait for the quarterly confirmation. The MCO track copay maximums and if the client exceeds their copay maximum, the MCO initiates claims adjustments and a notice to the provider to repay the client for any copays overpaid. The MCO adjusts the claim(s) paid to the provider(s) to remove the copay amount (thus paying the provider more) and the provider is instructed to reimburse the copay amount to the client. Any notice sent to the client must include instructions for the client to contact the MCO to obtain directions for getting a refund of any copayments made that exceed the max for the quarter if those copayments have not already been repaid by the provider(s).
Since most pharmacies only re-process claims within a limited time window, and the member usually pays the copayment at the time of service, if a member should exceed their copay max and the reimbursement needs to occur on the pharmacy side, it is acceptable with HSD for the MCO to issue an overpayment check directly to the member.

Notification updates – When the copay max for clients in a Case Number changes, the MCO needs to notify the clients of this change. Changes are to be made prospectively only. Changes effective within a quarter are to be pro-rated for the quarter

☒ Other process:

The eligibility system, ASPEN, maintains the amount of the monthly income for the family unit. The following description is how ASPEN supplies the information and how MCO's use the information:

ASPEN will calculate for each client a copay maximum (out of pocket maximum) that is the most that a client has responsibility towards any copayments for Medicaid services. ASPEN calculates the amount as 5% of the household monthly income. A household for purposes of this calculation is all clients who share the same Case Number.
ASPEN sends this monthly copay maximum to the MMIS and the MMIS passes it along in the Enrollment Roster file.
Although the copay max calculated by ASPEN is a monthly amount, HSD has agreed to the application of copay max at a quarterly level instead of monthly.

■ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

The copayment amounts that could be charged are negligible; therefore, the Human Services Department (HSD) does not anticipate that recipients will incur copayment amounts that cause them to meet or exceed the family limit.

HSD uses the following methods to inform recipients and providers of general cost sharing provisions and of personal cost sharing data including applicable copayment amounts and copayments already paid:

1. HSD providers are informed through both formal and informal regulations and notices.
2. HSD providers may inquire about the cost sharing policy by calling the New Mexico Medicaid fiscal agent's provider help desk.
3. HSD providers can access the applicable cost-sharing amounts on the provider web portal maintained by MAD's fiscal agent.
4. HSD providers can also access applicable cost-sharing amounts through the Medicaid Eligibility Verification

System (MEVS).
5. Providers may also contact the relevant managed care organization to check on cost sharing amounts, if applicable.

See two answers above for information regarding notifications sent by MCOs.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. No

☑ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The provider is responsible for reimbursing the recipient for any copayment amount collected over the aggregate limit.

☑ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Recipients must contact the Income Services Division (their county income worker) to report any changes in their circumstances which would result in a change to their family aggregate limit.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

PRA Disclosure Statement

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