8.308.14.1 ISSUING AGENCY: New Mexico Human Services Department (HSD)
[8.308.14.1 NMAC - N, 1-1-14]

8.308.14.2 SCOPE: This rule applies to the general public.
[8.308.14.2 NMAC - N, 1-1-14]

8.308.14.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.14.3 NMAC - N, 1-1-14]

[8.308.14.4 NMAC - N, 1-1-14]

8.308.14.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.14.5 NMAC - N, 1-1-14]

8.308.14.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.14.6 NMAC - N, 1-1-14]

8.308.14.7 DEFINITIONS:

A. Co-payment: A fixed dollar amount that must be paid at the time a MAD service is provided or a prescription is filled.

B. Emergency medical condition: A medical or behavioral health condition manifesting itself in acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
   (1) placing the member’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   (2) serious impairment of bodily functions;
   (3) serious dysfunction of any bodily organ or part; or
   (4) serious disfiguration to the member.

C. Unnecessary utilization of services:
   (1) The unnecessary utilization of a brand name drug means using a brand name drug is not on the first tier of a preferred drug list (PDL) instead of a alternative lesser expensive drug item that is on the first tier of a PDL, unless in the prescriber’s estimation, the alternative drug item available on the PDL would be less effective for treating the member’s condition, or would likely have more side effects or a higher potential for adverse reactions for the member.
   (2) The unnecessary utilization of an emergency department (ED) is when a member presents to an emergency room for service when the condition of the member is not an emergency medical condition and considered non-emergent after considering the medical presentation of the member, age, and other factors, but also alternative providers that may be available in the community at the specific time of day.
[8.308.14.7 NMAC - N, 1-1-14]

8.308.14.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.14.8 NMAC - N, 1-1-14]

8.308.14.9 COST SHARING IN MEDICAID MANAGED CARE PROGRAM: The medical assistance division (MAD) imposes cost-sharing (out-of-pocket) provisions on certain members, certain categories of eligibility and on certain services. Cost-sharing includes co-payments, coinsurance, deductibles, and other similar
charges. The member’s HSD contracted managed care organization (MCO) is required to impose the following co-
payments as directed by MAD and in accordance with federal regulations.

A. General requirements regarding cost sharing:

(1) The MCO or its contracted providers may not deny services for a member’s failure to pay the co-
payment amounts.

(2) The MCO must take measures to educate and train both its contracted providers and members on

cost-sharing requirements, and must include, at a minimum:

(a) educating and working with the MCO’s hospital providers on the requirements related to

non-emergency utilization of the emergency department (ED); and

(b) for co-payments required in the case of a non-emergency utilization of an ED (an

unnecessary use of services) the hospital is required, before imposing cost sharing, to provide the member with a

name of and location of an available and accessible provider that can provide the service with lesser or no cost

sharing and provide a referral to coordinate scheduling; if geographical or other circumstances prevent the hospital

from meeting this requirement, the cost sharing may not be imposed.

(3) The MCO shall not impose cost-sharing provisions on certain services that, in accordance with

federal regulations, are always exempt from cost-sharing provisions. See CFR 447.56, Limitations on Premiums

and Cost Sharing, 8.200.430 NMAC and 8.302.2 NMAC.

(4) The MCO shall not impose cost-sharing provisions on certain member categories of eligibility
[populations] that, in accordance with federal and state regulations and rules, are exempt from cost-sharing

provisions. The MCO and its contracted providers are required to impose co-payments on its members in the case of

unnecessary utilization of specific services as outlined in Subsection B of Section 9 of this rule, unless the [eligible
recipient] member is exempt from the copayments; see Subsection B of Section [40] 9 of this rule.

(5) Payments to MCO contracted providers: In accordance with 42 CFR 447.56, Limitations on

Premiums and Cost Sharing and New Mexico state statute 27-2-12.16:

(a) the MCO must reduce the payment it makes to a non-hospital contracted provider by the

amount of the member’s applicable cost sharing obligation, regardless of whether the provider has collected the

payment or waived the cost sharing; and

(b) the MCO must not reduce the payment it makes to a contracted hospital provider by the

amount of the member’s cost sharing obligation if the contracted hospital provider is not able to collect the cost

sharing obligation from the member.

(6) At the direction of MAD, the MCO must report all cost-sharing amounts collected.

(7) The MCO may not impose more than one type of cost sharing for any service, in accordance with

42 CFR 447.52.

(8) The MCO must track, by month, all co-payments collected from each individual member in the

household family to ensure that the family does not exceed the aggregate limit (cap). The cap 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.

(9) 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. The MCO shall be responsible for assuring the

provider is aware that:

(a) the provider shall be responsible for refunding to the member any copayments the provider

collects after the [eligible recipient] member has reached the co-payment cap (five percent of the [eligible

recipient’s] member’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;

(b) 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; and

(c) failure to refund a collected copayment to a member and to accept full payment from the

MCO may result in a credible allegation of fraud, see 8.351.2 NMAC.

B. Unnecessary utilization of services co-payments: The use of a brand name prescription drug in

place of a generic [therapeutic] therapeutically equivalent on the PDL and the utilization of the emergency room for

non-ED services are both considered to be unnecessary utilization of services. [Some members are exempt from

copayments for unnecessary utilization of services.] Providers shall charge the following co-payment amounts on

other MAP eligible recipients or members, including ABP, only in the event of a non-emergent use of the ED or

unnecessary uses of a brand name drug. No other co-payments apply.
(a) $3 for unnecessary use of a brand name drug;
(b) $8 for non-emergent use of the ED if the eligible recipient or member has an income of less than or equal to 150 percent of FPL;
(c) no co-payment is applied when the claim is for a co-insurance, deductible or co-payment following payment from a primary payer, including medicare;
(d) no co-payment is applied when the service is rendered at an IHS, tribal 638, or urban Indian facility;
(e) the provider shall not charge these co-payments when:
   (i) the eligible recipient or member is native American;
   (ii) the eligible recipient or member is in foster care or has an adoption category of eligibility;
   (iii) the eligible recipient or member does not have a MAP category of eligibility such as being eligible only for the department of health children’s medical services program; or
   (iv) the eligible recipient or member resides in a nursing facility or a facility for individuals with intellectual disabilities (IID) and has an institutional care category of eligibility.

1. When a member obtains a brand name prescription drug in place of a generic therapeutic equivalent on his or her MCO’s PDL, the MCO and dispensing pharmacy must impose a co-payment in the amount specified by MAD for the member, unless the member is exempt from copayments for unnecessary utilization of services or the use of the drug does not meet the definition for unnecessary utilization of a brand name drug as defined in this section. The MCO is responsible for determining when this unnecessary utilization of service has taken place and if so, the dispensing pharmacy is responsible for collecting the co-payment from the member.

2. The unnecessary utilization of a brand name drug shall not apply to legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.

3. The MCO shall develop a co-payment exception process, to be prior approved by MAD, for legend drugs when generic alternatives are not tolerated by a member.

8.308.14.10 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS: The copayment amounts, the application and exemptions of copayments are determined by MAD. See CFR 447.56, Limitations on Premiums and Cost Sharing, 8.200.430 NMAC and 8.302.2 NMAC.

HISTORY OF 8.308.14 NMAC: [RESERVED]