TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 14 CO-PAYMENTS [~~COST SHARING~~]

8.308.14.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.14.1 NMAC - Rp, xx-xx-17]

8.308.14.2 SCOPE: This rule applies to the general public.
[8.308.14.2 NMAC - Rp, xx-xx-17]

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 - Rp, xx-xx-17]

8.308.14.4 DURATION: Permanent.
[8.308.14.4 NMAC - Rp, xx-xx-17]

8.308.14.5 EFFECTIVE DATE: XX, XX, 2017, unless a later date is cited at the end of a section.
[8.308.14.5 NMAC - Rp, xx-xx-17]

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 - Rp, xx-xx-17]

8.308.14.7 DEFINITIONS:

A. Co-payment: A co-payment is a fixed dollar amount that a medicaid recipient must pay directly to a provider for a service, visit or item. A co-payment is to be charged at the time of service or receipt of the item.
[8.308.14.5 NMAC – Rp, xx-xx-17]

[~~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 that is not on the first tier of a preferred drug list (PDL) instead of an 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 the hospital determines the condition does not require emergency treatment after considering the medical presentation of the member, the age of the member, alternative providers that may be available in the community at the specific time of day, and other relevant factors. The co-payment is assessed when the member is told that the condition does not require emergency treatment and the member still choses to continue with the treatment in the ED.~~]
[8.308.14.7 NMAC - Rp, xx-xx-17]

8.308.14.8 RESERVED [~~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 - Rp, xx-xx-17]

8.308.14.9 CO-PAYMENTS IN THE MEDICAID MANAGED CARE PROGRAM: [~~COST SHARING IN MEDICAID MANAGED CARE PROGRAM:~~] MAD requires co-payments for specific categories of medicaid beneficiaries for certain types of services, as set forth in regulation at 8.302.2 (G) NMAC. The member's HSD contracted managed care organization (MCO) is required to administer co-payments as directed by MAD and in accordance with state and federal regulations. See 8.302.2 (G) NMAC for a detailed description of co-payment rules. For purposes of this Section, a medicaid beneficiary enrolled with a MCO is referred to as a 'member.'[~~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. Payments to MCOs: In accordance with 42 CFR 447.56(d), MAD calculates its payments to the MCOs to include co-payments established under the medicaid state plan (for beneficiaries not exempt from co-payments), regardless of whether the MCO imposes the co-payments on its members or whether co-payments are collected.

B. General MCO requirements regarding co-payments:

(1) The MCO and its contracted providers must ensure that co-payments are not charged for exempt medicaid beneficiaries, as set forth in regulation at 8.302.2 (G) NMAC, Subparagraph (2); or for exempt services, as set forth in regulation at 8.302.2 (G) NMAC, Subparagraph (3).

(2) The MCO and its contracted providers must adhere to all responsibilities for charging, collecting and reporting co-payments, as set forth in regulation at 8.302.2 (G) NMAC, Subparagraph (4).

(3) The MCO and its contracted providers must adhere to and ensure all beneficiary rights and responsibilities of their members, as set forth in regulation at 8.302.2 (G) NMAC, Subparagraph (5).

(4) The MCO and its contracted providers must charge co-payment amounts to members as set forth in regulation at 8.302.2 (G) NMAC, Subparagraph (7) through (12). Separate co-payment requirements may not be established by the MCO or its contracted providers.

(5) The MCO must take measures to educate and train its contracted providers and members on all co-payment requirements. Information about member co-payments must be included in the MCO member handbook, on MCO member cards, and in the MCO's provider portal.

(6) When a co-payment is required, the MCO must assume that the co-payment applies and deduct the co-payment from the claim prior to paying the contracted provider, regardless of whether the co-payment was actually collected.

C. MCO co-payment tracking requirements: The MCO shall track the accumulation of co-payments toward the aggregate limit of five percent of the member's household income, as defined in 8.302.2 (G) NMAC, Subparagraph (5)(b). The MCO must notify members of their co-payment accumulations as follows:

(1) Initial notification: The MCO must send a co-pay maximum initial notice to all member households that are subject to co-payments. The notice informs the household of its quarterly co-payment aggregate maximum. The MCO must also notify member households when there is a reported and verified change in income, as determined by the HSD income support division (ISD), that revises the aggregate maximum amount.

(2) Quarterly summary of co-payment maximum: On a calendar quarter basis, and more often if a member household reaches its co-payment maximum before the end of a quarter, the MCO must report the member household's accumulation of co-payments toward the aggregate maximum, to include the accumulation of co-payments for the most recent quarter and for the previous two quarters.

(3) Notice of approaching aggregate maximum: Once a member household has incurred co-payments totaling four percent of the member's household income, the MCO must send a notice to the member household immediately to notify the household of its co-payment accumulations that quarter and alerting the household that it is approaching the five percent aggregate maximum.

(4) Notice of aggregate maximum: If a member household meets the aggregate maximum prior to the end of a calendar quarter, the MCO must send a notice to the member household immediately to notify the household that it has reached the aggregate maximum and that the household may not be charged further co-payments for the remainder of the quarter. The MCO must also provide information to its contracted providers that no further co-payments may be charged to the member household for the remainder of the quarter.

(a) If the household has been charged co-payments that exceed the aggregate maximum, the MCO must initiate claim adjustments and send a notice to the contracted provider(s) who charged the

co-payments to repay the member household for any co-payments collected above the maximum amount within 10 working days, as set forth at 8.302.2 (G) NMAC, Subparagraph (4)(i).

(5) Upon request by any member household subject to co-payments, the contracted MCO must be able to provide each member household with an accounting of the household's accrued co-payment total(s) per quarter.

D. MCO requirements for contracted providers: The MCO must report back to the provider when a co-payment has or has not been applied to the provider's claim. This is done, at a minimum, using the remittance advice, explanation of benefits (EOB), or equivalent electronic transaction. The MCO is responsible for assuring that the provider is aware of the requirements set forth at 8.302.2 (G) NMAC.

[8.308.14.9 NMAC - Rp, xx-xx-17]

~~[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 ~~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~~ member ~~is exempt from the copayments; see Subsection B of Section~~ 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~~ member ~~has reached the co-payment cap (five percent of the~~ 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 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 of specific categories of eligibility are exempt from copayments for unnecessary utilization of services~~

~~(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.]~~

[8.308.14.9 NMAC - N, 1-1-14; A, 6-1-14]

~~**[8.308.14.10 MEMBER RIGHTS AND RESPONSIBILITIES:**~~

~~A. To avoid a co-payment for the use of the ED, the member is responsible to utilize other alternative medical care when his or her current medical presentation does not meet the MAD medical necessity of an ED visit.~~

~~B. When a MAD benefit has a co-payment assigned for a MAP category of eligibility, the eligible recipient will at the time of service make payment or make arrangements with the provider for payment at a later date.~~

~~C. A member shares the responsibility to track his or her co-payments for each quarter. The member has the right to request from his or her MCO at any time an account of his or her family's household co-payment total per quarter. If the member believes he or she has met the family's household OOP limit, he or she may request the provider to wait for future co-payments if the member has contacted his or her MCO to determine if the OOP limit has been met.~~

~~D. If a member had reached his or her family's household OOP limit but was not aware of it at the time the member paid a co-payment, the provider must refund the member the co-payment.~~

~~(1) The provider must refund the member within 10 working dates after the member requests a reimbursement of the paid co-payment or the member's MCO notifies the provider that the member's OOP limit has been met.~~

~~(2) The member may notify verbally or in writing his or her MCO of the provider's failure to refund the co-payment within the required timeframe.~~

~~(3) Failure of the MCO to intervene to have its contracted provider refund the co-payment within 10 working days of the member notifying the MCO constitutes a MCO adverse action and the member may file a MCO appeal and if applicable, a HSD administrative hearing. See 8.308.15 and 8.352.2 NMAC for detailed information.~~

~~(4) The member may also contact the HSD program integrity bureau after he or she has complied with Paragraph (2) and (3) above to report the provider's refusal to refund the member's co-payment as such action may result in a credible allegation of fraud.]~~

8.308.14.10 CO-PAYMENT AMOUNTS IN MANAGED CARE PROGRAMS: Medicaid co-payment amounts and the application of co-payments are determined by MAD. See 42 CFR 447.56, *Limitations on Premiums and Cost Sharing*, and 8.302.2 NMAC.

[8.308.14.11 NMAC – Rp, xx-xx-17]

HISTORY OF 8.308.14 NMAC: [RESERVED]