MANAGED CARE PROGRAM
COST SHARING
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TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 14 COST SHARING

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 DURATION: Permanent.
[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. **Unnecessary utilization of services:**

(1) The unnecessary utilization of a brand name drug means using a brand name drug is that 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 determined to be 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 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.

(a) This includes, but is not limited to, educating and working with the MCO's hospital providers on the requirements related to non-emergency utilization of the emergency department (ED).

(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 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 a service unless the eligible recipient is exempt from the copayments for unnecessary utilization of services; see Section 10 Subsection B 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 month. 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 has reached the co-payment cap (five percent of the eligible recipient's family's income, calculated on a monthly 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.

(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 preferred drug list (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.

(1) When a member obtains a brand name prescription drug in place of a generic therapeutic equivalent on his or her member'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. 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]

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]

History of Repealed Material: [RESERVED]