State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT
8.302.2 NMAC BILLING FOR MEDICAID SERVICES
8.308.14 COST SHARING

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to amend the following rules that are part of the New Mexico Administrative Code (NMAC): 8.302.2 *Billing for Medicaid Services* and 8.308.14 *Cost Sharing*.

In accordance with the 2016 General Appropriations Act, which directs the Department to "pursue necessary federal authority to include additional cost-sharing requirements for recipients of Medicaid services, including co-payments for certain services", the Department is proposing to amend 8.302.2 and 8.308.14 NMAC rules to apply co-payments to some Medicaid-covered services. The proposed co-payments are consistent with federal rules regarding co-payments.

Co-payments are amounts that Medicaid recipients pay directly to a provider for a service, visit, or item. Co-payments are to be charged at the time of service or receipt of the item. Certain services and populations are exempt from any co-payments, which means that no mandatory co-payments will be charged for those services or populations.

New wording in the proposed rules specifies the amount of each co-payment; to whom the co-payment applies; the categories of eligibility and services that are exempt from co-payments; the responsibilities of Medicaid providers for charging, collecting and reporting co-payments; the responsibilities of contracted managed care organizations (MCOs) for tracking co-payments; the rights and responsibilities of Medicaid beneficiaries; and other specific information regarding the application of co-payments.

The chart below summarizes a Medicaid beneficiary's applicable co-payment responsibilities, as proposed in 8.302.2 NMAC:

	Children's Health Insurance Program (CHIP)	**Working Disabled Individuals (WDI)**	**Other Adult Group – Category of Eligibility (COE) 100** Beneficiaries with income greater than 100% of the federal poverty level (FPL)	**Other Medicaid Categories** All FPLs and most COEs
Outpatient office visits	$5/visit	$5/visit	$5/visit	No co-payment
Inpatient hospital stays	$50/entire stay	$50/entire stay	$50/entire stay	No co-payment
Outpatient surgeries	$50/procedure	$50/procedure	$50/procedure	No co-payment
Prescription drugs, medical equipment, and medical supplies	$2/prescription	$2/prescription	$2/prescription	No co-payment
Non-preferred prescription drugs	$8/prescription	$8/prescription	$8/prescription	$8/prescription
Non-emergency use of the hospital emergency department	$8/visit	$8/visit	$8/visit	$8/visit

Summary of General Information in the Proposed Rules

Co-payments are not to be charged to the following exempt Medicaid beneficiaries: (a) Native Americans who are active or previous users of the Indian Health Service (IHS), tribal 638 health programs, or urban Indian health programs, who are coded as Native American in the eligibility and enrollment information technology (IT) system; (b) Persons who are receiving care in an intermediate care facility for individuals with intellectual disabilities (ICF-IID); (c) Persons who are enrolled only in the qualified Medicare beneficiary (QMB), specified low-income Medicare beneficiary (SLIMB), or qualified individuals programs; (d) Persons who are covered only under the Medicaid family planning program; (e) Persons who are enrolled in the program of all-inclusive care for the elderly (PACE); (f) Persons who are enrolled in the 1915(c) developmentally disabled waiver program; or (g) Persons who are receiving hospice care.

Co-payments are not to be charged for the following exempt services: (a) Community benefit services, nursing facility stays, or home and community based (HCBS) waiver services; (b) Hospice care services; (c) Family planning services, procedures, surgeries, prescription drug items, supplies, and devices; (d) Pregnancy-related health care, including tobacco cessation treatment for pregnant women, prenatal drug items, and postnatal care; (e) Laboratory, radiology and diagnostic laboratory tests and measurements ordered by a practitioner; (f) Emergency services; (g) Preventive services, including well-child visits, immunizations, periodic health exams; and covered preventive care and screenings as advised by the U.S. Preventive Services Task Force A and B recommendations; (h) Preventive dental cleanings and exams; and covered routine vision care services; (i) Services provided to minors that are protected under minor consent laws; (j) Behavioral health outpatient visits, inpatient hospital stays, and psychotropic

drug items; (k) Labor and delivery inpatient obstetric stays; (l) Services rendered to treat provider preventable conditions as defined at 42 CFR 447.26(b); (m) Services rendered before an individual's determination of Medicaid eligibility, even if covered retroactively; (n) Services rendered under the Medicaid school-based services (MSBS) program; (o) Services rendered under agreement with the Department of Health (DOH) Children's Medical Services program; or (p) Services covered by Medicare or a Medicare Advantage plan, or following payment by another primary insurer when the Medicaid payment is made toward a deductible, co-insurance, or co-payment determined by the primary payer.

A Medicaid provider or provider who is contracted with a Medicaid managed care organization (MCO) must adhere to the rules for charging, collecting, and reporting co-payments.

A provider may not deny services to a beneficiary on account of the beneficiary's inability to pay the co-payment when the household has income at or below 100% FPL. Before charging a co-payment, the provider must confirm the beneficiary's eligibility information by checking the beneficiary's MCO member card or information in the Medicaid provider portal to verify if a co-payment applies.

If a service subject to co-payments is provided, the Medicaid beneficiary remains liable for payment of the co-payment amount. The provider must apply the co-payment and may attempt to collect any unpaid charges at the time of services, at a later appointment, or by billing the Medicaid beneficiary.

Medicaid co-payments incurred by all beneficiaries in the household may not exceed an aggregate limit of five percent of the household's income, as applied on a calendar quarterly basis. If the beneficiary has a break in Medicaid coverage within the quarter, co-payment accruals toward the household maximum continue to apply during the quarter and do not reset until the following calendar quarter.

For more detailed information on the responsibilities of a provider or the rights and responsibilities of Medicaid beneficiaries, refer to the text of the proposed rule changes.

Summary of the Application of Co-payments in the Proposed Rules

The co-payment for outpatient office visits is charged for non-preventive care outpatient office and clinic visits, hospital outpatient department visits for physician or other practitioner services, non-preventive dental visits, urgent care visits, and outpatient professional therapies. For a single service that requires multiple visits to complete, such as a crown, orthodontia, or dentures, a co-payment is applied only on the date of the initial service.

The co-payment for inpatient hospital stays is charged per hospital stay. Only one co-payment is charged per inpatient stay, including when a patient is transferred from one hospital to another hospital. When an inpatient Medicaid beneficiary is transferred to another hospital, the co-payment is charged by the original hospital.
The outpatient surgery co-payment is charged for outpatient surgeries performed in office settings, outpatient facilities, and ambulatory surgical centers that are performed separately and

distinct from an office clinic or outpatient visit. The co-payment applies only to the primary surgical procedure performed.

Co-payments for prescription drugs, medical equipment, and medical supplies are charged for prescribed drugs, medical equipment, and medical supplies for a prescription, purchased item or monthly rental.

Co-payments for non-preferred prescription drugs are charged when a non-preferred prescription drug is not on the first tier of a preferred drug list. The co-payment for non-preferred prescription drugs does not apply if (a) in the prescriber's estimation, the lower-cost alternative drug item available on the PDL is either less effective for treating the beneficiary's condition or would have more side effects or a higher potential for adverse reactions; and (b) the prescriber has stated that the non-preferred drug is medically necessary on the prescription. If there is no medical justification for the use of a non-preferred drug, the co-payment is to be assessed by the pharmacy provider.

Co-payments are not applied to family planning drugs or items, drugs for pregnancy-related conditions, or 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 co-payment for non-preferred prescription drugs applies to beneficiaries enrolled in any Medicaid category of eligibility and at any income level, unless the service or recipient is specifically exempted in the rule.

Co-payments for non-emergency use of the hospital emergency department (ED) are charged only after specific conditions are met. This co-payment applies to beneficiaries enrolled in any Medicaid category of eligibility and at any income level, unless the service or recipient is specifically exempted in the rule. Non-emergency care is defined as any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health determines that immediate unscheduled medical care is not required. If it is determined that the condition is not an emergency and that care could have been provided appropriately elsewhere, and the individual still opts to be treated in the hospital ED, then the individual will be required to pay the co-payment. This process does not limit a hospital's obligations for screening and stabilizing treatment of an emergency medical condition under Section 1867 of the Social Security Act; or modify any obligations under either state or federal standards relating to the application of a prudent-layperson standard for payment or coverage of emergency medical services by MAD or any contracted MCO.

Before providing non-emergency services and imposing co-payments for such services, the hospital providing care must (a) conduct an appropriate medical screening under 42 CFR 489.24, subpart G, to determine that the individual does not need emergency services; (b) Inform the individual of the amount of his or her co-payment obligation for non-emergency services provided in the ED; (c) Provide the individual with the name and location of an available and accessible alternative non-emergency services provider; (d) make a determination that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser co-payment or no co-payment if the individual is otherwise exempt from co-

payments; and (e) make a referral to coordinate scheduling for treatment by the alternative provider. If the beneficiary chooses to receive services from the alternative provider, the co-payment may not be assessed. If the beneficiary has been advised of the available alternative provider and of the amount of the co-payment due, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital shall assess the co-payment.

VI. RULES

These proposed rules will be contained in 8.302.2 and 8.308.14 NMAC. The register and proposed rule language are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/registers.aspxx and http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx. If you do not have internet access, a copy of the proposed register and rule may be requested by contacting MAD outside of Santa Fe at 505-888-997-2583 extension 7-6252 or in Santa Fe 827-6252.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective October 1, 2017.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held in the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road Santa Fe on July 14, 2017 at 9:00 a.m. Mountain Daylight Time (MDT).

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Medical Assistance Division in Santa Fe at 505-827-6252. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Human Services Department
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Recorded comments may be left at (505) 827-1337. Interested persons may also address comments via electronic mail to: madrules@state.nm.us. Written mail, electronic mail and recorded comments must be received no later than 5 p.m. MDT on July 14, 2017. Written comments and recorded comments will be given the same consideration as oral testimony made at the public hearing.

X. PUBLICATIONS

Publication of these rules approved by:

BRENT EARNEST, SECRETARY
HUMAN SERVICES DEPARTMENT