Susana Martinez, Governor
Brent Earnest, Secretary
Nancy Smith-Leslie, Director

September 14, 2017

The Human Services Department (the Department), Medical Assistance Division (MAD), is amending the following rules that are part of the New Mexico Administrative Code (NMAC):

8.308.2 NMAC, Managed Care Program, Provider Network
8.308.6 NMAC, Managed Care Program, Eligibility
8.308.7 NMAC, Managed Care Program, Enrollment and Disenrollment
8.308.8 NMAC, Managed Care Program, Member Education
8.308.9 NMAC, Managed Care Program, Benefit Package
8.308.10 NMAC, Managed Care Program, Care Coordination
8.308.11 NMAC, Managed Care Program, Transition of Care
8.308.13 NMAC, Managed Care Program, Member Rewards
8.308.15 NMAC, Managed Care Program, Grievances and Appeals
8.308.21 NMAC, Managed Care Program, Quality Management
8.302.3 NMAC, Medicaid General Provider Policies, Third Party Liability Provider Responsibilities

NM Statute Section 9-8-6 (2016) authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

Notice Date: October 17, 2017
Hearing Date: November 20, 2017
Adoption Date: Proposed as February 1, 2018
Technical Citations: 42 CFR 438 subparts A through J

These changes are being proposed to match the requirements of federal rules. The Centers for Medicare and Medicaid Services (CMS) published federal rules, effective July 5, 2016, that updated Medicaid managed care requirements which the Department must now implement. The federal rules align the requirements governing Medicaid managed care programs, where feasible, with those of other major sources of health care coverage, including Qualified Health Plans and Medicare Advantage plans. The citation for the federal rule is 42 CFR 438 subparts A through J.

MAD reviewed the current rules related to managed care to assure they will be in compliance with federal requirements. They were also reviewed for currency and clarity. Necessary changes are being proposed as amendments to the existing managed care organizations (MCO) rules listed above. Also, amendments are being proposed to 8.302.2 NMAC, Medicaid General Provider Policies, Third Party Liability Provider Responsibilities, because of its relationship to managed care organizations.

8.308.2 NMAC MANAGED CARE PROGRAM – PROVIDER NETWORK

Significant proposed changes include: (1) clarifications and new responsibilities for provider enrollment to meet federal requirements; (2) adds MCO provider access standards; (3) adds a section

regarding MCOs contracting with the Indian health service, tribally operated facilities, and urban Indian clinics; (4) adds standards for MCOs regarding credentialing providers. No proposed changes are new limits on services or eligibility, or otherwise negatively impact managed care members.

8.308.6 NMAC MANAGED CARE PROGRAM - ELIGIBILITY

Significant proposed changes include: (1) a correction to the list of Medicaid recipient categories that are not enrolled in managed care. This is a correction only and does not change who is actually enrolled in managed care; (2) replaces "12 months" with "13 months", pursuant to a federal rule that specifies a newborn is enrolled for 13 months starting with the month of birth.

8.308.7 NMAC MANAGED CARE PROGRAM – ENROLLMENT AND DISENROLLMENT

Significant proposed changes include: (1) Changes the auto assignment eligibility period from two months to six months or less; (2) includes language clarifying the retroactive span of eligibility considered for enrollment in managed care "to not to exceed two years" and deleted references to time periods prior to January 1, 2014; (3) adds language clarifying member enrollment periods prior to changing MCO and the time period for issuance of a member identification card by an MCO is changed to 20 calendar days following notification of enrollment. This time period was previously 30 days.

8.308.8 NMAC MANAGED CARE – MEMBER EDUCATION

Significant proposed changes include: (1) changing the title to read "Member Rights, Responsibilities, and Education; (2) language was added to assure that MCOs comply with federal requirements with regard to supplying informational and educational materials to members and for the civil rights and other rights that MCOs are required to provide to members of an MCO.

8.308.9 NMAC MANAGED CARE – BENEFIT PACKAGE

Significant proposed changes include: (1) language was added to assure MCOs follow federal requirements regarding providing benefits, citing applicable federal citations; (2) added language to require that MCOs meet all behavioral health parity requirements; (3) added the benefit of health home services; (4) wording was added to physical health benefits to include birth center benefits, licensed birthing center benefits and other covered delivery services; a change is being made stating that routine vision care is not a benefit for a member 21 years and older whose eligibility is as an Alternative Benefit Plan beneficiary. Previously the rule stated that one routine eye exam per member was allowed every 36 months. This change is consistent with the federal requirements regarding Alternative Benefit Plan coverage; (5) added additional information regarding the MCOs' responsibility to cover pharmacy services; (6) added the MCOs' responsibility to cover plan B and long acting reversible contraception items; (7) included crisis services and opioid treatment programs as behavioral health services that MCOs are to cover; (8) a new section incorporates wording from the federal rule on emergency services and stabilization to assure a member has adequate care during an emergency situation; and (9) a new section incorporates wording from the federal rule with regard medical necessity, authorization requirements, and comparability to fee-for-service Medicaid coverage which generally assures the MCO provides necessary services to members.

8.308.10 NMAC MANAGED CARE PROGRAM – CARE COORDINATION

A significant proposed change adds language to clarify the MCO requirement to employ or contract with a Native American care coordinator or contract with a community health representative to serve as a care coordinator.

8.308.11 NMAC MANAGED CARE PROGRAM – TRANSITION OF CARE

A significant proposed change adds information clarifying the circumstances under which a member will be provided care coordination and information regarding MCO identification of members who transition from institutional care to the community.

8.308.13 NMAC MANAGED CARE PROGRAM – MEMBER REWARDS

A significant proposed change adds clarifying language that a member may participate in a managed care member rewards program.

8.308.15 NMAC MANAGED CARE PROGRAM – GRIEVANCES AND APPEALS

Significant proposed changes include: (1) changes to the rule to assure that the federal requirements regarding grievances and appeals relating to MCOs and their members will be followed in the New Mexico Medicaid program; (2) proposed wording to clarify who may file a grievance or appeal and who may request an administrative hearing, and expanding the extent to which an "authorized provider" may represent a member in the process; (3) proposed wording was added to clearly differentiate between provider appeals and grievances vs. member appeals and grievances and to differentiate between the requirements for expedited appeals vs. standard appeals; (4) language was added to assure an MCO provides sufficient information to a provider or member to better explain why an adverse action is being taken; that an MCO seeks additional information from a provider prior to making a final decision; and provides information explaining the adverse decision; (5) proposed wording states a provider or a member may file a grievance at any time rather than within 30 calendar days of the event triggering the grievance; (6) the rule clarifies a grievance cannot be filed regarding an adverse benefit determination or the MCOs final grievance decision which is a federal provision; (7) new language states an appeal must be filed within 60 calendar days of the notice of adverse action - previously the time frame was 90 days for a standard appeal and 30 days for an expedited appeal; (8) new language clarifies what constitutes a MCO adverse action against a member, incorporating the federal definition of Adverse Benefit Determination; (9) many other definitions are added or expanded for clarity including new wording to allow a member's treating provider to act as the member's authorized representative when the member is medically incapacitated or when the member's authorized representative cannot be located, and the member requires immediate medical care until such time as the member appoints an authorized representative or the member's current authorized representative is located; (10) the proposed rule also specifies that the MCO expedited member appeal process must be concluded and a final decision made by the MCO within 72 hours after a request is made with provisions for extending the time frame when necessary; (11) language specifies the MCO standard member appeal process must be concluded and a final decision made by the MCO within 30 calendar days of the request for the appeal with provisions for the extending the time frame when necessary.

8.308.21 NMAC MANAGED CARE PROGRAM – QUALITY MANAGEMENT

A proposed change provides additional information and requirements regarding the quality management programs, including additional criteria for mandatory and optional External Quality Review Organization activities.

8.302.3 NMAC THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

Significant proposed changes include clarifying when claims must be denied due to the recipient having other insurance resources or third party liability and when claims cannot be denied; and specifying that MCOs must follow these requirements established by federal regulation.

This proposed amendments will be contained in 8.308.2 NMAC; 8.308.6 NMAC; 8.308.7 NMAC; 8.308.8 NMAC; 8.308.9 NMAC; 8.308.10 NMAC; 8.308.11 NMAC; 8.308.13 NMAC; 8.308.15 NMAC; 8.308.21 NMAC; and 8.302.3 NMAC.

The register and proposed rule amendments are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/registers.aspx 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 at 505-827-6252.

The Department proposes to implement these rules effective February 1, 2018. 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, New Mexico, on November 20, 2017, from 10 a.m. to 12 p.m., Mountain Standard Time (MST).

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 MAD in Santa Fe at (505) 827-6252. The Department requests at least 10 working 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.

Interested persons may submit written 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 oral comments may be left by calling (505) 827-1337. Electronic comments may be submitted to madrules@state.nm.us. Written, electronic and recorded comments will be given the same consideration as oral testimony made at the public hearing. All comments must be received no later than 5:00 p.m. MST, on November 20, 2017.