State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT
8.302.3 NMAC - MEDICAID GENERAL PROVIDER POLICIES, THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES
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
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III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
FINAL RULES

V. BACKGROUND SUMMARY

New Mexico Human Services Register Volume 40, Register 23, dated October 17, 2017, issued the proposed rules:
8.302.3 NMAC - Medicaid General Provider Policies, Third Party Liability Provider Responsibilities
Chapter 308 Managed Care Program
8.308.2 NMAC - Provider Network
8.308.6 NMAC - Eligibility
8.308.7 NMAC - Enrollment and Disenrollment
8.308.8 NMAC - Member Rights, Responsibilities, and Education
8.308.9 NMAC - Benefit Package

8.308.10 NMAC - Managed Care Program, Care Coordination
8.308.11 NMAC - Transition Of Care
8.308.13 NMAC - Member Rewards
8.308.15 NMAC - Grievances and Appeals
8.308.21 NMAC - Quality Management

Section 9-8-6 NMSA 1978, 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 May 1, 2018
Technical Citations: 42 CFR 438 subparts A through J

A public hearing was held on November 20, 2017 to receive public comments and testimony on this proposed rule. The Human Services Department (the Department) received four oral testimonies, no recorded comments and five written comments.

SUMMARY OF COMMENTS:

OVERALL PROMULGATION PROCESS

Verbal Testimony

One individual requested detailed information on how the Department conducted its tribal notification.

Department Response: Tribal governments and their health care providers received a detailed summary of the proposed changes. The Department also employs a full-time MAD Tribal Liaison who is available to receive requests for specific information concerning this Tribal Notification Letter 17-09. Theresa Belanger may be reached at 505-827-3122 or at Theresa.Belanger@state.nm.us.

8.302.3 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

Section 12 Process Used if Third Party Liability Identified
Subsection D

One commenter recommended the Department delete the term *"agency"* in the second sentence believing it may be ambiguous. The commenter included another comment for this sentence stating that payment mechanisms outside the Medical Assistance Division (MAD) Fee-for-Service fee schedule may be used to determine pricing, such as the Department's contracted managed care organizations (MCOs).

Department Response: The Department, after consideration, has amended this Subsection to now read "*The establishment of third party liability takes place when MAD or the MCO receives confirmation from the provider or a third party resource indicating the extent of the third party liability.*" The proposed last sentence has been removed and the wording was changed for clarity.

Section 18

Subsection A Insurer Responsibilities Paragraph (4)

One commenter stated the Department's Medicaid Managed Care Service Agreement Section 4.18.13.1.4.3 allows the MCO time to finalize MCO-initiated recoveries that may take longer than 12 months and requests the Department consider amending the sentence so the Department can only receive a recovery payment if a MCO failed to initiate the recovery of the payment up to 12 months following the date of service.

Department Response: HSD has always recognized the 12-month period as described by the amended language. The rule was changed to state: ***If the MCO fails to initiate recovery*** *within 12 months* ***following the original payment date,*** *the payment must be made to HSD.*

CHAPTER 308 MANAGED CARE PROGRAM

8.308.2 NMAC PROVIDER NETWORK

General Rule Comment

One individual provided oral testimony that supported MCOs contracting with Native American tribes providing better service for care coordination as well as the medical models being implemented by the MCOs. He said there are difficulties in accessing the four MCOs. He is pleased that MCOs are working with the tribe's Community Health Representatives (CHRs) to act as care coordinators or contact points.

Department Response: The Department appreciates the individual for alerting us regarding the tribal concerns. HSD will work with the MAD Tribal Liaison to further examine these concerns.

Section 10 Subsection A Paragraph (4)

One commenter requested the Department consider the primary care team to be inclusive of advanced practice providers, such as physician assistants (PAs) and certified nurse practitioners (CNPs). The commenter asserted the description of a primary care team may not actually represent the existing practice of care for New Mexico patients as there are parts of New Mexico that do not readily have access to physicians to be a '*lead physician*.' The commenter further stated that currently the workforce shortage, particularly in rural areas of New Mexico, requires that a PA or CNP lead teams. The definition of a primary care team that is only led by a '*lead physician*' will further limit access to care in areas that are in dire need of services.

Department Response: This Paragraph did not have a proposed change; however for clarification purposes, the Department directs the commenter to Paragraph (2) of this Subsection, which allows a CNP or a PA to act as the member's PCP. Paragraph (4) is specifically for *teaching hospitals* where a team is necessary to ensure supervision of the hospital's students, residents, and interns to treat a member. The language stands as it currently exists.

Section 11 Subsection D Standards for Access

One commenter expressed that allowing an increase to the radius that a member must travel for behavioral health services appears to be an attempt to bypass two significant rights in the Medicaid Act – the reasonable promptness provision found in 42 U.S.C. § 1396a(a)(8) and the network adequacy provision at 45 CFR § 156.230. When a network is inadequate, members may

have to travel long distances or wait a long time to receive care. In the worst case scenario, members may not be able to access necessary care. The commenter stated that it has been their experience that their constituency has reported long wait times for services or that there is an inability to access services either in their communities or statewide. The commenter said that it is not unusual for children in communities outside the Rio Grande corridor to be told that although they might be eligible for a service, there are no providers available in their communities. The MCOs informed the commenter's constituency that the members were not being denied the service because there wasn't a provider available. Therefore, the MCOs believed they were not denying the service which prevents the members from requesting a MCO Member Appeal.

Department Response: It is not the intent of the rule to reduce the availability of behavioral health services to recipients in underserved areas. This rule does not actually change the Standards for Access for behavioral health. The current rule does not specify the Standards of Access for behavioral health in terms of a percentage of members in rural or frontier counties and the distance of travel. However, such information is contained in the HSD contracts with the MCOs. The new information on the Standards of Access in the proposed rule is consistent with the current MCO contracts. In the proposed rule, under Section 12, Access to Care, the waiting time requirements for behavioral health appointments are stated and have not been reduced from the current rule. Subsection E under Section 12 continues to state that *"For non-urgent behavioral health care, the request for appointment time shall be no more than 14 calendar days, unless the member requests a later time."*

One of the primary goals of HSD is to help encourage and develop behavioral health providers in underserved areas. As part of its Strategic Plan, the Behavioral Health Collaborative has a workforce group specifically designated to help with the issue of behavioral health services in underserved areas.

In order to add clarity to the MCO requirements, the final rule has additional wording that states **"The MCO must provide transportation as necessary to meet the Standards of Access."**

Section 12 Access to Health Care Services

Subsection C

One commenter asked if the requirement for routine asymptomatic member-initiated dental appointment turn-around time is only for a member who is already an established patient of the dental practice.

Department Response: The Department thanks the commenter for seeking clarification. The Department does not make a distinction between new patients and established patients. The language stands as proposed.

Subsection L

One commenter appreciated the Department setting specific and short timelines for a prescription to be ready for pick up.

Department Response: The Department welcomes the commenter's appreciation. The language stands as proposed.

Subsection R

One commenter appreciated that the requirement to provide behavioral health crisis care face-to-face within two hours will be part of this rule.

Department Response: The Department welcomes the commenter's support. The language stands as proposed.

Section 16 Standards for Credentialing and Re-credentialing

One commenter described being frustrated that the Department has not availed itself to provide instructions to simplify and streamline the MCO credentialing process for behavioral health providers, particularly smaller provider agencies. A behavioral health agency must provide each MCO with the same information which is duplicative and expensive to the agency attempting to enter into a contract with each MCO. The commenter directs the Department to 42 CFR 438.217 which requires the Department to establish and maintain a uniform credentialing and re-credentialing policy. The commenter recommended the Department design and administer a single, statewide MCO credentialing process to simplify the current administrative burden so more practitioners might be encouraged to become Medicaid providers.

Department Response: The Centers for Medicare and Medicaid Services (CMS) managed care final rule 42 CFR 438.214 requires contracted MCOs to follow the Department's credentialing and re-credentialing policies. The Department recognizes this as an important issue. The language stands as proposed.

Section 17 Provider Transition

One commenter stated the amendments appeared to eliminate the protections a member has when his or her provider leaves the MCO network. The proposed amendments no longer require the provider to submit a transition plan to HSD for all affected members. The commenter further stated that from the experience of the last several years, provider transitions are not uncommon and requested the proposed amendments be removed.

Department Response: The provision was removed from the proposed rule because it is not a Centers for Medicare and Medicaid Services (CMS) requirement; however, HSD still requires a transition plan. The requirement was moved to the MCO Policy Manual. The language stands as proposed.

8.308.6 NMAC ELIGIBILITY

Section 9 Managed Care Eligibility Subsection C

One commenter questioned why the term "*native*" in Native American is not capitalized.

Department Response: The Department adheres to standards set by the State Records Center and Archives for the New Mexico Administrative Code (NMAC) which require that certain types of words not be capitalized, such as the *human services department, centers for medicare and medicaid services,* and specifically, *native* in Native American. The Department must comply with State Records and Archives formatting requirements; therefore, the language stands as proposed.

Section 10 Special Situations Subsection A and
8.308.7 NMAC Section 9 Managed Care Enrollment: Subsection B Newly Eligible Recipient, and Subsection E Eligible Recipient Lock-In

The Department received comments concerning two rules: 8.308.6 NMAC and 8.308.7 NMAC with corresponding Sections and Subsections.

(1) The commenter contended 8.308.6 NMAC Section10 Subsection A, 8.308.7 NMAC Section 9 Subsection B; and 8.308.7 Section 9 Subsection E may treat similarly situated members differently, because the effective date of enrollment for a newborn is the first of the month in which the baby was born, regardless of the actual date of birth. Thus, a baby born earlier in the month may have more time to change MCOs than a baby born later in the month. In this example, the latter member would effectively be afforded only two months to change MCOs. In contrast, if a member were born on November 1, 2017, that member would be allowed three full months to change MCOs. To avoid this potential inequity, the commenter suggested the Department maintain the time frame as 90 calendar days.

(2) The commenter pointed out a potential conflict with the proposed rule language as the January 1, 2018 revised Medicaid Managed Care Services Agreement Amendment 8 Section 4.2.5.4 states *"The mother shall have one (1) opportunity anytime during the ninety (90) Calendar Days from the effective date of enrollment to change the newborn's MCO assignment."* The commenter recommended in order to avoid possible inequity and conflict, Sections and Subsections of 8.308.6.10.A, 8.308.7.9.B; and 8.308.7.9.E should be changed to afford 90 calendar days as stated in the MCO contract.

Department Response: The Department proposed the change because all enrollments and eligibility dates are based on *completed months* and not a specific number of calendar days. The rule clarifies how the process actually functions. The language stands as proposed.

8.308.7 NMAC ENROLLMENT AND DISENROLLMENT

Section 10 Disenrollment

One commenter noted that despite the statement to the contrary, it appeared this rule gives MCOs permission to disenroll a member for behavior related to his or her disability. There was no statement about assessing whether the level of care coordination is adequate or what reasonable accommodation could be made available (such as providing additional supports and services) to continue vital Medicaid services. Further, this Section said nothing about what the Department is going to do to ensure continuity of care for that member. The commenter believed the rule must spell out the steps necessary to achieve compliance with the Americans with Disabilities Act and other legal requirements. Further, the rule must state how the Department and the MCOs will work to provide continued care for a MAP eligible individual. Implementation of the proposed rule by MCOs would be illegal, and extremely dangerous to vulnerable MAP eligible recipients.

Department Response: Section 10, Subsection A, of current rule states: *"The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of his or her utilization of medical or behavioral health services, his or her diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either a particular member or other members)."*

The Department agrees that the wording "*(except when his or her continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either a particular member or*

other members)" seems to imply that the MCO, on its own, can make a decision to disenroll a member, which is not true. The way the process works is that only HSD/MAD can enroll or disenroll a member. The MCO may report a perceived inability to furnish services to a member recipient for any reason, at which point, MAD would require that supports, care coordination, and reasonable accommodation, as necessary be provided in order to continue to serve the member. In order to make this technical correction to the rule, the wording *(except when his or her continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either a particular member or other members)"* is being removed from the rule.

The Department also notes that the requirement for a MCO to comply with the Americans with Disabilities Act is in each of their contracts with HSD.

In addition, wording was added to Section 8.308.10.9 Care Coordination, Subsection A, item (2) when addressing the issue of a member refusing to participate in Care Coordination, to state ***"The member remains enrolled with the MCO with no reduction in the availability of services."***

8.308.8 NMAC MEMBER RIGHTS, RESPONSIBILITIES, AND EDUCATION
Section 11 Rights and Responsibilities Subsection A Paragraph 15
Verbal Testimony

One individual providing oral testimony requested clarification on what the Department means by *"any other applicable federal and state laws."*

Department Response: The Department thanks the individual for bringing this question forward for clarification. A member in a MCO has a number of federal and state laws which protect his or her health care rights. That same member also has other rights as a resident of New Mexico and the United States which may provide other protections concerning the member's health care. The Department, in this rule, provides that all the applicable statutes, laws, regulations and rules that may apply to distinct populations are to be followed. The language stands as proposed.

Section11 Member Rights and Responsibilities Subsection A Paragraph (10)

One commenter provided information that a number of their many clients face tremendous difficulty exercising their right to appeal MCO adverse action decisions. The commenter believed the proposed language will make the process even less clear by blurring the grievance, appeal and administrative hearing avenues. The commenter suggested that to accurately inform members of their rights to grieve or appeal, the rights must be listed separately and recommended Subsection A Paragraph (10) be divided into two paragraphs to read *"(10) to voice grievances concerning the care provided by the MCO; (11) to appeal any action regarding medicaid services that the member believes is erroneous; see 42 CFR 431.220.*"

Department Response: The Department agrees with the commenter that Paragraph (10) be revised and renumbered. Paragraph (10), (11) and (12) reads:

*"**(10)** to voice grievances concerning the care provided by the MCO;*

***(11)** to appeal any action regarding medicaid services that the member or his or her authorized representative or authorized provider believes is erroneous;*

(12) *to protect the member, his or her authorized representative or authorized provider who uses the grievance, appeal, and HSD administrative hearing processes from fear of retaliation;*"

Section 12 Member Health Records

One commenter contended the proposed amendment rewrites language regarding a member's access to his or her records as it appears Section 12 is designed to limit access to the member's electronic records only. As is widely known, there are many people in New Mexico who do not have internet access in their homes. The commenter believes the Department must make provisions for access to paper copies of the member's records who cannot receive an electronic version of their medical records in a manner that protects their health care record privacy. The Department's clear obligations to provide Medicaid eligible recipients with access to their records is not met by limiting that access to electronic records.

Department Response: The Department directs the commenter to 8.310.2 Section 13 which states "*A provider cannot bill a MAP eligible recipient or his or her authorized representative for the copying of the MAP eligible recipient's records, and must provide copies of the MAP eligible recipient's records to other providers upon request of the MAP eligible recipient."* The Department instructs providers they cannot charge an eligible recipient or member or the member's other providers for printed or electronic copies of member's medical records. The amendments to Section 12 of this rule do not limit a member to receiving his or her health records to electronic media; but instead, to continue to require a provider to prepare the records in an electronic format, if so requested by the member. The member under 8.310.2 NMAC may also request a printed copy of his or her health record. The Department has amended the final rule to read "*The MCO shall provide a member with access to electronic or* ***hard copy*** *versions of his or her personal health records.*"

8.308.9 NMAC BENEFIT PACKAGE

Section 10 Medical Assistance Division Program Rules

One commenter agreed that covered services should be provided in the amount, duration and scope to reasonably achieve its purpose as stated in 42 CFR 440.230.

Department Response: The Department appreciates the commenter's response. The language stands as proposed.

Section 11 General Program Description

One commenter expressed a number of concerns and challenges their clients are facing with securing initial and ongoing care coordination from the MCOs. In particular, the clients with behavioral health concerns have faced difficulties accessing care coordination. Often the clients received a list of resources instead of coordination. The commenter requested the Department ensure that its contracted MCOs provide this service in Centennial Care.

Department Response: The Department welcomes the opportunity to proactively work with its MCOs to ensure that those members who qualify for care coordination receive quality, responsive and accountable coordination to assist the member in accessing his or her covered benefits. The Department thanks the commenter for bringing forward these concerns which relate to administration of the Centennial Care program and not to the content of the rule. The language stands as proposed.

Subsection E

The commenter asserted the Department and its MCOs are not providing parity to behavioral health services in the same manner as physical health services. The commenter reported members are told they are eligible for a behavioral health service and then told that the services do not exist in the members' community. The MCO offered no further assistance to help the members obtain access to services. The commenter went on to state that if the service were for a member with asthma, the MCO would not let the member go without treatment, while if the member meets the criteria for Serious Emotional Disturbance (SED), the member goes without services because the service is not available in his or her community.

Department Response: The Department thanks the commenter for expressing these important concerns on behalf of their clients. The Department has conducted the federally required Behavioral Health Parity Analysis. The analysis is available on HSD's website at: http://www.hsd.state.nm.us/LookingForInformation/nm-mhpaea-report-final-mental-health-parity-report-for-website.pdf. The language stands as proposed.

Section 12 General Covered Services

Subsection I

The commenter appreciated the Department appropriately including oxygen as covered durable medical equipment.

Department Response: The Department thanks the commenter and the language stands as proposed.

Subsection L (renumbered as *Subsection M* in final rule)

The commenter appreciated the Department expanding home health agency services and other nursing care. The proposed language provided an explanation of the different avenues by which member children may access personal care services.

Department Response: The Department thanks the commenter and the language stands as proposed.

Subsection R (renumbered as *Subsection T* in final rule)

The Department received two comments on this Section.

(1) The commenter expressed confusion with this Section, wondering why the amendment fails to address the broad group of physical health benefits offered under this Section; instead the Department appeared to have limited services to school-based settings and wondered why it is specifically addressing birthing benefits.

Department Response: Subsection S (now Subsection T) is not intended to include all services. The entire Section 12 enumerates various covered services. This Subsection is intended to describe only some additional separate physician and professional services, not otherwise included in Section 12. Various birthing options are included to assure all options are made available to a member. The wording and numbering has been revised to make the meaning clearer. The amended Subsection T reads:

"***T. Physical health services:***

(1) Primary care and specialty care services are found in the following NMAC rules: 8.310.2, 8.310.3, 8.320.2, and 8.320.6. The services are rendered in a hospital, clinic, center, office, school-based setting, and facilities and settings as approved, including the home.

(2) The benefits specifically include:

(a) *labor and delivery in a hospital;*

(b) *labor and delivery in an eligible recipient's home;*

(c) *labor and delivery in a midwife's unlicensed birth center;*

(d) *labor and delivery in a department of health licensed birth center; and*

(e) *other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.*

(f) *The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology.*

(g) *The MCO shall participate in MAD's birthing options program."*

(2) One commenter expressed concerns that care coordination benefits were not included in this Section. The commenter believes that by not listing care coordination as a covered benefit in this Section, members are denied information about their rights to appeal an adverse determination when their health risk assessment determines a lower level of care coordination. When a lower level of care coordination is determined, a member may not have access to a benefit that could be of enormous benefit to a member with complex needs.

Department Response: Care coordination is not a covered benefit in Centennial Care but rather a service for eligible members provided by the managed care organizations based on member need. For more information about the care coordination program, see 8.308.10 NMAC. The language stands as proposed.

Section 14 Pharmacy Services
Subsection D

One commenter supported the Department's language that directs a MCO to cover a brand name drug or drug item that is not generally on his or her MCO's formulary or preferred drug list (PDL) when a MCO expedited or standard member appeal final decision or HSD expedited or standard administrative hearing final decision has determined the drug or item is medically necessary for the member.

Department Response: The Department appreciates the commenter's support. The language stands as proposed.

Subsection I

One commenter believed the Department's decision to expand its coverage of over-the-counter (OTC) items will provide members with early intervention, prevention, or maintenance regimens that can reduce the possibility of an acute illness requiring more intensive or costly medical intervention. The commenter particularly appreciated that HSD recognized its obligation to provide medically necessary OTCs to members under 21 years of age as required by the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program.

Department Response: The Department appreciates the comment. The language stands as proposed.

Section 15 Early and Periodic Screening Diagnosis and Treatment Services Subsection F Tot-to-Teen Health Checks

One commenter believed it is incredibly important the Department decided to include language not only ensuring EPSDT age appropriate health screens, but that referrals, and appropriate

services and follow-up care must be ensured as well. This has always been the case, yet there is value in making this right explicit.

Department Response: Subsection F refers to referrals and follow-up care. To emphasize the importance of those aspects of the EPSDT program, a citation has been added to direct the reader to the 8.320.2 NMAC rule for more information; otherwise, the language stands as proposed.

Section 16 Reproductive Health Services Subsection A Paragraph (2)

One commenter is grateful for the inclusion of Plan B and long-acting reversible contraception, as they are important options for women.

Department Response: The Department thanks the commenter for supporting the amended language. The language stands as proposed.

Section 17 Preventive Physical Health Services
Subsection G Screens Paragraph (6)

One commenter appreciated the listing of several types of mandatory screening exams and more detailed requirements for EPSDT screening for elevated blood lead levels for infant members as it can identify children who may experience a developmental delay due to lead exposure.

Department Response: The Department thanks the commenter. Information regarding blood lead level testing and other screenings is updated as necessary through a MAD supplement to program rules. The language stands as proposed.

Section 19 Behavioral Health Services
Subsection A Paragraph (1)

The Department found a technical error in the coverage span for a member to receive Applied Behavior Analysis (ABA) services. The amended Paragraph reads "*1) Applied behavior analysis: The benefit package includes applied behavior analysis (ABA) services for a member **12 months** of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member **12 months** to three years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral."*

Subsection A Paragraph (5) Crisis Services
Verbal Testimony

One individual provided oral testimony expressing concern as to who is responsible for the care of a member when family members are contributing. The individual reminded the Department of its new verbiage that says *"treat first"* and is wondering when a member's family and community are involved. The parties need to first do the psych-social evaluation and figure out the services for the member, not only for his or her own safekeeping, but also for the safekeeping of the community. The commenter asked when a member resides in-between Bernalillo and Santa Fe counties, which county will provide better services?

Department Response: The Department appreciates the individual bringing this concern to its attention. The Department agrees that family and community support is a vital

component to a member's treatment. The concept of *'treat first'* allows a behavioral health practitioner to immediately provide services to the member until such time as a full evaluation or assessment is completed. Concerning the individual's request for the Department to recommend a county with *"better"* services, the Department cannot comment on the quality of services in individual counties. The language stands as proposed.

Subsection A Paragraph (5)

There were three oral testimonies presented by three individuals concerning Paragraph (5). The individuals stated the proposed language refers to three types of crisis services: *(a) 24-hour crisis telephone support; (b) mobile crisis teams; and (c) crisis triage centers*; however, Item (c) is not defined in the proposed rule language. Individuals stated that Bernalillo and Santa Fe counties are looking into or developing initiatives for crisis treatment services. As the proposed language does not provide details, the individuals:

(a) requested a definition as to what constitutes short-term residential stabilization;

(b) sought a time frame when the Department of Health (DOH) will promulgate NMAC rules for crisis centers; and

(c) requested a determination if there will be some coverage for non-residential crisis treatment services.

Department Response: The Department thanks the individuals providing testimony for appearing in person to voice their concerns. The Department plans to issue rules that will address the commenter's concerns regarding short-term and non-residential crisis treatment. The Department cannot comment on the timeline for DOH to promulgate its rules for crisis centers. The language stands as proposed.

Subsections A and B

One commenter asserted that while these Sections stated the MCOs shall cover the listed behavioral health services, the Department has not fulfilled its duty to ensure the services that the MCOs must provide are indeed available. The commenter requested HSD make the commitment to develop a statewide behavioral health system that includes medically necessary and legally required services available to members in need of the services. As an example of this, the commenter pointed out that many of the listed community-based services that should be available for children and youth are not available statewide. These services include, but are not limited to: Behavior Management Skills, Day Treatment Services, Multi-systemic Therapy, Psych-social Treatment, Treatment Foster Care I and II, Behavioral Health Respite Care, Family Support Services, Non-accredited Residential Treatment Centers (RTC) and group homes. Accredited Residential Treatment Centers are in limited numbers in the state. Each residential placement facility can choose which child or youth it admits. Children who are rejected by all RTCs in the state are sent to the most restrictive settings available – out of state, away from their families and communities. In other words, the Department pays MCOs a capitated rate per member per month for services that are not provided by the MCO. Children in need of these services do not get them despite the promise to members and the CMS that they would be available. The commenter contended the Department has not done its duty to ensure these services are provided.

Department Response: The proposed changes to this Section include new crisis services and a clarification of Medication Assisted Treatment in Opioid Treatment Programs. The comment does not relate to the proposed changes. The language stands as proposed.

Section 24 Emergency and Post Stabilization Services

The commenter believed this Section may have been incorrectly numbered. It appears that it should be *8.308.**9**.24* instead of *8.308.**2***. It is very helpful to have the wording from the federal regulation to ensure members have the full benefit of emergency and post-stabilization services.

Department Response: The Department thanks the commenter for alerting it of this error and for its support of the proposed language. The Section citation now reads ***"8.308.9.24"***.

Section 25 Additional Coverage Requirements

General Comment

One commenter stated that it is very helpful to have the wording of the federal regulation related to medical necessity, authorization requirements and comparability to Fee-for-Service Medicaid coverage.

Department Response: The Department thanks the commenter for the observation. The language stands as proposed.

Subsection E Additional Coverage Requirements Paragraph (7) Item (a)

One commenter suggested the proposed language may create confusion and controversy because it is not well aligned with current statutory law and the Medicaid Managed Care Services Agreements. NMSA 1978, Section 27-2-12.18 requires a response within three business days when a uniform prior authorization form is used. Section 4.12.10.1.7 of the Agreements is to the same effect. The commenter recommended the Department remove Item (a) or align Item (a) to the Department's Medicaid Managed Care Agreement Section 4.12.10.1.7.

Department Response: The 24-hour response requirement is in the federal act and in the CMS final rule of May 5, 2016 related to managed care. The language stands as proposed.

8.308.10 NMAC CARE COORDINATION

General Comments on Section 10

One commenter stated it continues to be gravely concerning that despite the Centennial Care's lofty goals and the legal requirements created by federal regulations, state rules, the MCO contracts and the MCO Policy Manual, care coordination does not provide comprehensive and integrated care for individuals with behavioral health care needs.

(1) The commenter stated care coordination must meet the requirements of the governing federal regulation, including the requirement that the services be provided ***"Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays."*** 42 CFR § 438.208 (b)(2)(i) (commenter's ***emphasis*** added). Although the current language in the proposed rule stated care coordination will facilitate access to services and actively manage transitions of care including participation in discharge planning, the commenter has often witnessed situations where care coordinators were not actively involved in discharge planning when a member was hospitalized or placed in an institutional facility. The current and proposed language does not define the circumstances in which a hospitalized member receives an in-person visit.

(2) Every child in an out-of-home placement requires Level 2 or 3 care coordination. To

minimize the likelihood that a child does not return to an out-of-home placement once discharged, the commenter stated it is imperative that care coordination begin while a child is in the out-of-home behavioral health placement, regardless of type, to guarantee continuity of care and actual connection with community-based services.

Department Response: Care coordination requirements for transitions of care are listed in 8.308.11. Additional care coordination requirements for transition of care are contained in the MCO agreements and the MCO Policy Manual. The language stands as proposed.

Section 9 Subsection G Electronic Visit Verification (EVV) System

One commenter stated the EVV configuration has a seven-day lag time which does not allow for gaps including late and missed visits to be addressed immediately. The Department removed this information from MCO Report #35. To be consistent, this information should be removed in this Section, as well. The commenter recommended the Department make the following revision *"(3) The MCO shall monitor and use information from the electronic verification system to verify that services are provided as specified in the member's CCP, and in accordance with the established schedule, including verification of the amount, frequency, duration, and the scope of each service."*

Department Response: The Department thanks the commenter for its recommendation and, after review, has revised Subsection G to read ***"(1) The MCO, together with the other MCOs, shall contract with a vendor to implement an electronic visit verification system in accordance with the federal Twenty First Century Cures Act. (2) The MCO shall maintain an EVV system capable of leveraging up to date technology as it emerges to improve functionality in all areas of the State, including rural areas."***

8.308.11 NMAC TRANSITION OF CARE

Section 9 Transition of Care

Verbal Testimony

The individual requested the Department work with its Income Support Division to ensure staff is uniformly trained.

Department Response: This testimony does not relate specifically to 8.308.11 NMAC. The language stands as proposed.

The Department received four comments concerning the opening of Section 9.

(1) One commenter drew the Department's attention to the third sentence of the opening of this Section which states *"Care coordination will be **provided** to members…"* The commenter recommended the Department amend the sentence to read, *"Care coordination will be **offered** to members who are..."* as a member has the right to decline care coordination services.

Department Response: The Department agrees with the commenter and the language will now read as recommended by the commenter.

(2) One commenter requested the Department reconsider its itemized Paragraph listing **(1)** through **(6)** of the opening description of Section 9 as to which members qualify for transitional care coordination services. The commenter stated there are "special circumstances" that would

trigger an offer of transition care coordination and suggested the Department remove "special circumstances" for clarity that may not be self-evident to a member. The commenter suggested the Department elaborate or add a defined term.

Department Response: The Department's intent was not to place additional challenges on a member accessing care coordination. The Department has removed *"with special circumstances"* from the final rule. The Department has added clarifying language which reads *"…Care coordination will be* ***offered*** *to members who are: (1) transitioning from a nursing facility* ***or out-of-home placement*** *to the community; (2)…"*

(3) Members turning 21 years of age:

(a) One commenter asserted that Paragraph (3) of the opening of Section 9, which offers transition care coordination to a member turning 21 years of age, may be confusing. The member may not recognize that he or she, as a healthy member with a care coordination level of 1, would have a need for this service. The commenter wondered if the Department is attempting to educate a member of the changes the member will have from accessing EPSDT program benefits to now accessing adult benefits, such as vision coverage. The commenter suggested that a better approach is requiring the MCO to mail educational materials to such members and remove Paragraph (3) from the opening of this Section.

Department Response: The MCO should provide members turning 21 years of age with relevant education materials, but that is not the purpose of this Section. The Department believes an offer of care coordination should be made to an individual turning 21 years of age by his or her MCO. The language stands as proposed.

(b) One commenter stated this Section specifically added particular circumstances in which care coordination is necessary to facilitate a transition, including transitioning from a higher level of care to a lower one, and a member turning 21 years of age. The commenter recommended that the starting age for transition care coordination be changed to *"turning 18 years of age"* rather than *"turning 21 years of age"*. The commenter asserted that upon a member turning 18 years of age, the member is now, for the first time, charged with the responsibility for his or her own medical decisions, which is often a particular challenge for people with disabilities. Young people also '*age out'* of the foster care system at 18 years of age rather than 21 years of age and are suddenly thrust into the world with very little support. They are extremely vulnerable at that juncture and would benefit from additional assistance.

Department Response: The age 21 is specified because that is the age through which federal policy mandates EPSDT services. The MCO is not limited by this Paragraph with regard to educating and coordinating care for a member whenever it is advantageous for the member, including any member at risk. The language stands as proposed.

(4) One commenter stated that adults meeting the criteria of Serious Mental Illness (SMI) and children and youth meeting the criteria of SED need care coordination assistance to facilitate a smooth transition to lower levels of care and to minimize the risk of re-institutionalization.

Department Response: The Department directs the commenter to the inclusion of language found in 8.308.11.9 NMAC that will support a member's access to care coordination when moving from a high level of care to a lower level of care. The additional language offers members leaving an out-of-home placement access to care coordination. The language stands as proposed.

Subsection A Paragraph (4)

One commenter directed the Department to Paragraph (4) of this Subsection which states *"The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption of the member's services."* The commenter requests the Department ensure that care coordination to facilitate transition at these junctures actually occurs.

Department Response: The Department thanks the commenter for the request. The Department works closely with the MCOs and will continue to monitor these services to ensure the members needing them will access the service. The language stands as proposed.

Subsection D Transition from Institutional Facility to Community

The commenter stated a member's transition from care in an institutional facility to care in his or her community is a particularly vulnerable time for the member. The commenter stated the identified *"methods"* in this Subsection seem to rely heavily on referrals for transition services rather than the MCO care coordinator taking affirmative steps to coordinate that transition. Furthermore, the commenter stated this Subsection seems to be more focused on discharge from longer term placements than, for example, acute hospitalizations or short term residential placements. Members meeting the criteria of SMI or SED should be receiving Level 2 or Level 3 transition care coordination. The commenter requested that both the care coordination rule 8.308.10 NMAC and this NMAC rule make this clear.

Department Response: The Department added out-of-home placements which would include children's residential treatment centers. This Section is not intended to limit the MCO's use of care coordination which is covered in a separate rule, 8.308.10 NMAC. The language stands as proposed.

8.308.13 NMAC MEMBER REWARDS

No oral testimony, recorded comment, or written or electronic comment received. The language stands as proposed.

8.308.15 GRIEVANCE AND APPEALS

Section 7 Definitions

Subsection B Adverse Actions Against a Member

The Department received three comments to the opening of Subsection B.

(1) One commenter suggested the Department amend 8.325.2 NMAC so the language found in 8.308.15 Section 7 Subsection B are aligned.

Department Response: The Department agrees with the commenter and it is currently drafting proposed amendment language to 8.352.2 and 8.354.2 NMAC to ensure there is alignment between all NMAC rules related to appeals, HSD administrative hearings, and preadmission screening and annual resident review (PASRR) administrative hearings. The language stands as proposed.

(2) One commenter described challenges MCO members face with filing a MCO appeal when the MCO has failed to issue a Notice of Action in a timely manner or when the MCO internally

changes a member's filed MCO appeal to a MCO member grievance without the member's or his or her authorized representative's or authorized provider's approval or consent. The commenter requested additional language in this rule to instruct the Department's MCOs to cease such actions.

Department Response: This requirement is new and covered in the proposed language found in Section 7 Subsection M Paragraph (3) of this rule which reads "*(3) A MCO cannot change a member's, or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor."* For additional clarity, in Section 8.308.15.12, Subsection C (2), wording was added to clarify that the expected date of MCO resolution of a grievance must be within 30 days of receipt of the grievance, which is a standard already in place.

(3) One commenter described challenges MCO members are facing with not meeting Medicaid-specific medical necessity criteria and diagnosis which would allow members to access additional and specialized services even though a parent, guardian or CYFD case worker believes the member does meet the SED criteria.

Department Response: The member has the right to file a MCO member grievance if he or she believes the provider is not appropriately assessing the member. The Department appreciates the comment; however, this rule isn't attempting to address the criteria associated with specialized services or who is qualified to a make a medical diagnosis. The language stands as proposed.

Subsection B Paragraph (1)

One commenter requested the Department separate language related to ***newly*** requested benefits which have been denied by the MCO in whole or part from language related to ***currently*** (***emphasis*** added by commenter) authorized benefits which have been then denied by the MCO in whole or part within this Paragraph.

Department Response: The Department joined 'newly requested benefits' and 'currently authorized benefits' into the opening instructions for Subsection B Paragraph (1). The Department has determined by doing so, the final language upholds the requirements under 42 CFR 438.400(b). The language stands as proposed.

Subsection C Adverse Action Against a Provider

One commenter expressed concern that allowing a non-contracted MCO provider to file a MCO provider appeal will undercut the MCO's ability to contract with providers.

Department Response: The Department requires MCOs to reimburse non-contracted providers under certain conditions or situations. The federal rule does not limit a provider's right to file an appeal only to a network provider. The situations in which a non-contracted provider is reimbursed are limited. The Department believes allowing such providers appeal rights will not negatively impact a MCO's ability to contract with providers. The language stands as proposed.

Subsection D Authorized Provider

One commenter raised two issues to this definition.

(1) The commenter expressed concerns a member may not understand the difference between an '*authorized provider*' and an '*authorized representative*' which may lead the member to not fully

follow his or her requirements when requesting a HSD expedited or standard administrative hearing.

Department Response: The Department directs the commenter to Section 11 Subsection A Paragraph (2) of the final rule which requires the MCO to provide *"information on how the member, his or her authorized representative or authorized provider can file a MCO member grievance and request a MCO expedited or standard member appeal and the resolution process for each."* The Department contends it is the responsibility of the MCO to assist whoever requests the member's appeal of his or her responsibilities, limitations in each role, and how to proceed through the MCO member appeal and request a HSD administrative hearing. The language stands as proposed.

(2) The commenter requested clarification as to what is meant by *"An authorized provider does not have the full range of authority as the authorized representative to make medical decisions on behalf of the member."* The commenter stated that traditionally an authorized representative, absent a health care power of attorney, cannot make medical decisions on behalf of the member.

Department Response: The intent of the wording is to clarify the authorized provider is limited in making medical decisions, consistent with the comment.

Subsection E Paragraph (2)

One commenter requested the Department amend the proposed language from *"The member's medical record must demonstrate that the member was incapacitated **or** the member's medical condition required immediate action prior to the authorized representative being located."* to read *"The member's medical record must demonstrate that the member was incapacitated **and** the member's medical condition required immediate action prior to the authorized representative being located."*

Department Response: The Department agrees with the commenter; the rule reads *"The member's medical record must demonstrate that the member was incapacitated **and** the member's medical condition required immediate action prior to the authorized representative being located."*

Subsection E Authorized Representative

One commenter agreed with the Department's position to allow, under limited situations, the member's provider to act as the member's authorized representative.

Department Response: The Department appreciates the commenter's agreement. The language stands as proposed.

Subsection E HSD Administrative Hearing or 'Fair Hearing' (renumbered as *Subsection F* in final rule)

One commenter requested the Department delete the term *'fair hearing'* throughout the rule and standardize the language to exclude any reference to *'fair hearing.'*

Department Response: The Department included *'fair hearing'* in the Subsection's heading because a number of members and others continue to use this term when referring to a HSD expedited or standard administrative hearing. While the Department understands the commenter's request to standardize the language, the use of the term *'fair hearing'* is in the best interest of the members. The language stands as proposed.

Subsection F HSD Administrative Hearing or 'Fair Hearing' and *Subsection G* HSD Expedited Administrative Hearing (renumbered as *Subsection I* in final rule)

One commenter requested the Department add to the definition of *"HSD standard administrative hearing"* and *"HSD expedited administrative hearing"* so that this Subsection would then read *"means an informal evidentiary hearing conducted by the HSD fair hearings bureau (FHB) in which evidence may be presented as it relates to an adverse action taken or intended to be taken, by the MCO* ***against a member.****"*

Department Response: The Department directs the commenter to Section 7 Subsection B which defines that a MCO adverse action taken or intended to be taken is against a MCO member. The language stands as proposed.

Subsection L MCO Expedited Member Appeal Paragraph (1)

One commenter suggested this definition means a MCO expedited member appeal must be granted, even when the MCO has determined the member's condition or situation does not meet the requirements for a MCO expedited member appeal.

Department Response: The Department understands the commenter's concern that a MCO cannot approve a request for an expedited appeal if the member's situation does not meet the criteria for an expedited appeal. The Department has added the words "*A request for*" to the definition so that it now reads *"A request for an expedited appeal is appropriate when the MCO, the member, his or her authorized representative, or the authorized provider believes that allowing the time for a standard member appeal resolution could seriously jeopardize the member's life, health, or his or her ability to attain, maintain, or regain maximum function."*

Subsection I MCO Standard Member Appeal Paragraph (1) and Paragraph (3) (renumbered as *Subsection M* in final rule)

The Department received two comments for this Subsection.

(1) One commenter suggested Paragraph (2) is not necessary because an authorized provider is already included in Paragraph (1).

Department Response: The Department thanks the commenter for the suggestion. However, instead of deleting Paragraph (2), the Department will delete the term *'authorized provider'* from Paragraph (1). The Department's position is that a member, his or her authorized representative and authorized provider have the right to request a MCO expedited or standard member appeal.

(2) One commenter stated that members have experienced MCOs changing their requests for MCO expedited or standard appeals to MCO member grievances without their consent.

Department Response: The Department, after reviewing the comments, has included a new Paragraph (3) to this Subsection. The additional language provides clear instructions to MCOs that they cannot change a member's or his or her authorized representative's or authorized provider's request for a MCO member appeal to a MCO member grievance without consent of the individual requesting the member appeal (member, authorized representative, authorized provider). Paragraph (3) reads *"A MCO cannot change a member's, or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor."*

Subsections M MCO Member Appeal and N MCO Member Grievance

One commenter stated the proposed language provides distinctions between what constitutes a MCO Member Appeal and MCO Member Grievance. The commenter reported their clients have experienced MCOs changing a member's request for a MCO member appeal to a MCO member grievance without the member's consent.

Department Response: The Department thanks the commenter for its agreement with the proposed language. Section 7 Subsection M Paragraph (3) reads *"A MCO cannot change a member's, or his or her authorized representative's or authorized provider's request for a MCO expedited or standard member appeal to a MCO member grievance without the written consent of the appeal requestor."*

Subsection O MCO Provider Appeal and Subsection Q MCO Provider Grievance

One commenter requested additional language to the definition restricting the provider appeal and grievance processes be open only to MCO contracted providers as the commenter contended such an action may remove a significant contracting incentive and result in fewer participating providers.

Department Response: The Department directs the commenter to Section 7 Subsection C of this rule. The Department has determined a non-contracted provider who intends to render or has rendered a MAD benefit based on limited conditions and situations has the right to request a MCO provider appeal. The language stands as proposed.

Subsection T Provider

One commenter requested in this definition, and definitions found under Subsections C, O and Q to limit provider rights to appeal to only MCO contracted providers.

Department Response: The Department directs the commenter to its responses found under Section 7 Subsections C, O and Q of this final register. The language stands as proposed.

Section 9 MCO Provider Grievance and Section 10 MCO Provider Appeals

One commenter requested that in both Sections, the term *'contracted'* be added to limit grievance and appeals to only those providers contracted with a MCO.

Department Response: Based on comments made in Sections 9, 10, and 11 (see below), the Department has amended Section 10 to read *"Upon a provider contracting with the MCO, the MCO shall provide at no cost a written description of its provider appeal policies and procedures* ***and instructions on how to act as a member's authorized provider*** *to the member's provider. The MCO will update in writing each of its providers with any changes to these policies and procedures.* ***The MCO will additionally provide to a non-contracted provider who is seeking to or has rendered services or items to the MCO's member policies and procedures informing the provider of his or her rights and responsibilities to be designated by a member or his or her authorized representative to act as his or her authorized provider, and how to request a MCO expedited or standard member appeal as the authorized provider.*** *"*

Section 11 General Information on MCO Member Grievances and Appeals Subsection A

Paragraph (1)
One commenter requested the term *'contracted'* be added to limit only MCO contracted providers the right to file a MCO provider grievance or appeal.

Department Response: The Department directs the commenter to its responses found under Section 7 Subsections C, O, Q, and T and Sections 9 and 10 of this final register. The language stands as proposed.

Paragraph (2) Item (d)
One commenter stated the removal of a two-tiered MCO standard member appeal process ends a cumbersome, time consuming and significant obstacle for members, authorized representatives and authorized providers to resolve the member's appeal.

Department Response: The Department thanks the commenter for its support. The change is required under new CFR language and this change will streamline the time a member must wait for a MCO member appeal final decision. The language stands as proposed.

Paragraph 2 Item (g)
One commenter appreciated the additional language to the rule requiring a MCO to contact the member's provider for supporting documentation prior to issuing a denial in whole or part of the prior authorization request.

Department Response: Requiring a MCO to reach out to the member's provider to provide additional information to substantiate the prior authorization request may reduce the number of member appeals requested. The language stands as proposed.

Subsection B MCO Member Grievance and MCO Expedited and Standard Member Appeal Rights and Responsibilities
Paragraph (1) Item (b)
One commenter sought clarification on the role and limitation of a designated spokesperson during a MCO expedited or standard appeal process.

Department Response: A spokesperson may assist the member, his or her authorized representative or authorized provider in a number of ways that are unique to him or her. Generally, the spokesperson is limited to assisting the individual who is requesting or has requested a MCO expedited or standard member appeal. The member or his or her authorized representative (not the authorized provider) may, through a signed release, allow the spokesperson to access the member's MCO medical file (in whole or in part). If the member or authorized representative does not sign a release, the spokesperson is limited to the information the member or authorized representative provides him or her. Only the member or his or her authorized representative or authorized provider may take action to request a MCO expedited or standard member appeal and fulfill the requestor's responsibilities during a MCO expedited or standard member appeal process. The language stands as proposed.

Paragraph (3) Member Grievance Item (b)
One commenter questioned how a member or authorized representative can file a MCO member grievance at the same time as the member or his or her authorized representative or authorized provider can request a MCO expedited or standard member appeal.

Department Response: The Department directs the commenter to Section 7 Subsections B, M, and N. Subsection B defines what constitutes a MCO adverse action intended or taken

against member. Subsection M defines a MCO member appeal based on the MCO's adverse action against a member. Subsection N defines a MCO grievance as the expression of dissatisfaction about any matter or aspect of the MCO or its operation that is not included in the definition of an adverse action. Since a grievance is different than an appeal, a member or authorized representative may file a MCO member grievance on non-adverse action related issues and a member or his or her authorized representative or authorized provider may request a MCO expedited or standard appeal based on adverse actions. The language stands as proposed.

Paragraph 4 MCO Expedited or Standard Member Appeal

The Department received four comments on this Paragraph.

(1) One commenter expressed concerns that their clients may experience challenges to submitting a written MCO standard member appeal request after submitting orally a MCO member appeal request.

Department Response: The Department directs the commenter to 42 CFR 438.402(c)(3)(ii) which states "*Appeal. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written signed appeal.*" As the CFR is specific on this issue, a MCO member, his or her authorized representative or authorized provider, when requesting an oral MCO standard member appeal, must follow up the request in writing. As the Department must comply with the CFR, the language stands as proposed.

(2) One commenter pointed out an inconsistency in statements. The Department required in the proposed version that for an expedited appeal the member, his or her authorized representative or the authorized provider must request the appeal within 13 calendar days of the date of the Notice of Action.

Department Response: The Department appreciates the commenter bringing this to its attention. The language has been changed to read *"A member, his or her authorized representative or authorized provider has the right to request a MCO expedited member appeal orally or in writing in accordance with his or her MCO procedures within **60** calendar days of the date of the notice of action of an intended or taken adverse action."*

(3) One commenter requested an explanation why the time frame to request an appeal was shortened from 90 calendar days to 60 calendar days.

Department Response: 42 CFR 438.402(c)(2)(ii) specifically states that a member has 60 calendar days from the date on the notice of adverse action in which to file a request for a MCO member appeal. The language stands as proposed.

Paragraph (4) Item (c)

(4) One commenter requested the term *"other action"* be removed through the rule, explaining the use of this term is ambiguous and may lead to controversy.

Department Response: An 'other action" is meant to allow a member to appeal his or her budget, setting, allocations and non-emergency transportation issues which are not included in the federal definition of "adverse action." The Department has added "other action" to Section 7 Subsection B which reads: ***"(2) Other actions include:*** *(a) a budget or allocation for which a member, his or her authorized representative, or authorized provider believes the*

*member's home and community-based waiver **benefit** or the member's budget or allocations were erroneously determined or is insufficient to meet the member's needs. (b) a denial, limitation, or non-payment of emergency or non-emergency transportation, or meals and lodging."*

Item (c)

One commenter requested the term "*mailing*" be changed to "*postmarked on the envelope*" throughout the rule. The commenter cites '*mailing*' is an ambiguous term, as it is not a concrete, objective indicator from which a timeline can be measured.

Department Response: The Department agrees with the commenter and has made such changes throughout the rule. Item (c) reads: "***When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.***" The clarifying language has been added to all relevant Sections of this rule, which are 8.308.15.11 Subsection B (4)(c); 8.308.15.13 Subsection A, and A (1); 8.308.14 Subsection A and A (1); and 8.308.15.15 Subsection A.

SECTION 13 MCO EXPEDITED MEMBER APPEAL PROCESS

One commenter interpreted this Section to say that a MCO is obligated to provide a continuation of the member's disputed current benefit once the member or his or her authorized representative or authorized provider requests a MCO expedited member appeal. The commenter based his or her understanding that the MCO has the authority to determine if the request for an expedited appeal meets the criteria for standing; therefore, the continuation of the disputed current benefit cannot go forward if the MCO denies an expedited appeal.

Department Response: Section 13 only applies to a MCO expedited member appeal. It is during the MCO expedited appeal process that the MCO determines if the requestor has standing for an expedited appeal. A MCO cannot at the time of the request for the continuation of the disputed current benefit know if the member's situation meets the requirements to go forward with the MCO expedited member appeal. The MCO is obligated to approve the member's continuation of the disputed current benefit until such time as the MCO denies the request for the MCO expedited member appeal or if the request meets the requirements for an expedited appeal, the disputed current benefit continues until the MCO expedited member appeal final decision letter ends the disputed benefit. However, if the date of final appeal decision letter is prior to the effective date of the adverse action, the MCO must continue the member's continuation of the disputed current benefit up to the Notice of Action's effective date. The language stands as proposed.

SECTION 14 MCO STANDARD MEMBER APPEAL PROCESS

Subsection D Paragraph (2) Item (b)

One commenter identified the misuse of one term in this Item: *"hearing"* instead of *"appeal"* extension.

Department Response: The Department agrees and the sentence now reads *"**(b)** that alerts the member, his or her authorized representative or the authorized provider of the possibility of **an appeal** extension of up to an additional 14 calendar days when…"* The Department thanks the commenter for bringing this to its attention.

Subsection E Time Frames Paragraph (1)

One commenter brought forward two separate comments for this Paragraph.

(1) The commenter noted the incorrect number of days in which a MCO standard member appeal may be requested, stating the time frame is correctly *30 calendar days* instead of *14 calendar days*.

Department Response: The Department thanks the commenter for noting the incorrect number of days. The Department has changed the time frame to read: "***(1)*** *The MCO must act as expeditiously as the member's condition requires, but no later than* ***30*** *calendar days after receipt of a request for a MCO standard member appeal…"*

(2) The commenter questioned why a MCO must make reasonable efforts to provide oral notice. The commenter believes this requirement would be burdensome and costly to the MCO.

Department Response: In reviewing this comment, the Department considered that the member has been waiting possibly 14 to 44 calendar days for a MCO standard member appeal final decision. It may also be another 90 to 104 calendar days before the member has a HSD standard administrative hearing final decision. The Department contends that *reasonable efforts* to reach out to orally notify the member are appropriate and do not place an undue burden on the MCO. The language stands as proposed.

Section 15 Continuation of a Disputed Current Benefit or Other Action

One commenter noted 42 CFR 438.420(a) (2) allows the requestor seeking a continuation of the member's disputed current benefit or other action has up to the date of the intended effective date of the MCO's adverse action to request the continuation of the disputed current benefit or other action.

Department Response: The Department agrees and has changed the language to read ***"However, if the date of the MCO expedited member appeal final decision letter is prior to the effective date of the Notice of Action's adverse action effective date, the MCO must continue the disputed current benefit up to the Notice of Action's adverse action's effective date."***

Subsection A

One commenter requested the term "*mailing*" be changed to "*postmarked on the envelope*" throughout the rule. The commenter cites '*mailing*' is an ambiguous term, as it is not a concrete, objective indicator from which a timeline can be measured.

Department Response: The Department agrees with the commenter and has made such changes throughout the rule to read: "***When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.****"*

Subsection B Paragraph (2)

One commenter expressed agreement with the Department's inclusion of the term *"possible responsibility"* concerning the repayment of a continuation of a disputed current benefit during the MCO member appeal process and requested the Department ensure the MCOs' notices contain this language.

Department Response: The Department will provide direction to the MCOs to include this language. The language stands as proposed.

Section 16 MCO Expedited Member Appeal and MCO Standard Member Appeal Final Decision and Implementation

Subsection A

One commenter requested the term "*mailing*" be changed to "*postmarked on the envelope*" throughout the rule. The commenter cites mailing is an ambiguous term, as it is not a concrete, objective indicator from which a timeline can be measured.

Department Response: The Department agrees with the commenter; the change reads "***When the mailing date is disputed or there is a discrepancy between the mailing date and the postmarked date, the postmarked date will prevail.****"*

Subsection F

One commenter wondered why the Department is limiting the number of days a member or his or her authorized representative must request a HSD expedited and standard administrative hearing when 42 CFR 438.408 (f) (2) provides up to 120 calendar days.

Department Response: The Department is within its authority to limit the time frame a member or his or her authorized representative must request a HSD expedited administrative hearing to 30 calendar days and a HSD standard administrative hearing to 90 calendar days. The CFR states that the member or his or her authorized representative must request a HSD administrative hearing no later than 120 calendar days from the MCO member appeal final decision letter. The Department made the change to be consistent with Fee-for-Service time frames for requesting a HSD standard administrative hearing which is 90 calendar days. The language stands as proposed.

Subsection F Item (1)

The Department received three comments for this Item.

(1) One commenter stated Paragraph (1) appears to allow a member or his or her authorized representative who did not request a continuation of the member's disputed current benefit at the time of the MCO expedited or standard member appeal, to request a continuation of the member's disputed current benefit during the member's HSD expedited or standard administrative hearing process.

Department Response: If the member's MCO member appeal decision letter is prior to the MCO Notice of Action's adverse action effective date, and during this time period the member or his or her authorized representative requests a HSD administrative hearing, the member or his or her authorized representative may request a continuation of his or her disputed current benefit. The Item reads "***(1) A member or his or her authorized representative or authorized provider may request and the member receive a continuation of the disputed current benefit at any time prior to the MCO notice of action's intended date the disputed benefit will be terminated. The request may be made even after the MCO expedited or standard member appeal final decision letter is issued if issued before the date the disputed benefit will be terminated.****"*

(2)(a) One commenter expressed concern the Department's language is inconsistent with 42 CFR 438.420(c)(2) by allowing a member's disputed current benefit that was approved during the MCO expedited or standard member appeal process to continue without interruption during the HSD expedited or standard administrative hearing process. The commenter suggested the

Department instead require the member or his or her authorized representative to re-request the continuation of the member's disputed current benefit at the time of the request for a HSD expedited or standard administrative hearing.

(2)(b) The commenter further stated that by not requiring a member or his or her authorized representative to request a continuation of the member's disputed current benefit there may be increased potential liability if the HSD expedited or standard administrative hearing final decision upholds the MCO's adverse action.

Department Response: The Department directs the commenter to 42 CFR 438.420 (c) which states *"Duration of continued or reinstated benefits. If, at the enrollee's request, the MCO or PIHP continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: … (3) A State fair hearing Office issues a hearing decision adverse to the enrollee."* The Department contends requiring a member or his or her authorized representative to again request the continuation of the member's disputed current benefit that was already approved and provided by the member's MCO places an unnecessary burden on the requestor and violates 42 CFR 438.420(c)(3) which specifically includes a HSD administrative hearing's final hearing decision letter as the ending point for the continuation of the disputed current benefit. The Department directs the commenter to a MCO's requirements to fully inform a member or his or her authorized representative of his or her possible liability to repay the disputed current benefit if the HSD expedited or standard administrative hearing final decision upholds the MCO's adverse action; see Section 16 Subsection G of this rule. The language stands as proposed.

Subsection F Item 1 and Item 2

One commenter expressed support for the Department's position that a member or his or her authorized representative is not required to re-request the continuation of the member's disputed current benefit upon requesting a HSD expedited or standard administrative hearing.

Department Response: The Department thanks the commenter for its support. The language stands as proposed.

Subsection I

One commenter expressed a possible inconsistency between Subsection F and this Subsection related to automatic continuation of a member's disputed current benefit. The commenter directed the Department to review the second sentence of Subsection I which states *"However, if the member or his or her authorized representative **elects** to continue the member's disputed current benefit or other action…"* The commenter proposed since there is an automatic continuation of the member's disputed current benefit or action through the HSD expedited or standard administrative hearing process, there cannot be an *'election'* to continue the member's disputed current benefit.

Department Response: The Department has removed the term *"elects"* and amended the sentence to read *"However, if the member or his or her authorized representative wants to continue the disputed current benefit…"*

8.308.21 NMAC QUALITY MANAGEMENT

Verbal Testimony

One individual stated that the State said it would devote attention to outcomes and move out of

the monitoring and reporting that MCOs are doing. The individual stated he has told the Department's Secretary several times that good data is necessary to measure outcomes. The two quality independent reports that were submitted qualify their report by stating the sample sizes are not large enough to do a good evaluation. If the quality contractors could increase the sample sizes, the individual hopes a better picture of outcomes will be presented.

Department Response: The Department thanks the individual and has taken the comment as a recommendation. The language stands as proposed.

Throughout the finalized rules, non-substantive changes were made to ensure consistency in language.

VI. RULES

These amendments will be contained in the following NMAC rules 8.302.3, 8.308.2, 8.308.6, 8.308.7, 8.308.8, 8.308.9, 8.308.10, 8.308.11, 8.308.13, 8.308.15, 8.308.21. The final register and rules are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/registers.aspx. If you do not have internet access, a copy of the final register and rules may be requested by contacting 505-827-6252.

VII. EFFECTIVE DATE

These rules will have an effective date of May 1, 2018.

VIII. PUBLICATION

Publication of these rules approved by:

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BRENT EARNEST, SECRETARY
HUMAN SERVICES DEPARTMENT

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Department Response: The Department thanks the individual and has taken the comment as a recommendation. The language stands as proposed.

Throughout the finalized rules, non-substantive changes were made to ensure consistency in language.

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