State of New Mexico
Human Services Department
Human Services Register

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NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

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III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
FINAL RULES

V. BACKGROUND SUMMARY

The Human Services Register Vol. 36, No. 35, dated October 29, 2013 issued the following proposed new Medical Assistance Division (MAD) provider rules for the implementation of Centennial Care:

8.302.2	Billing for Medicaid Services
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Public hearings were held Monday, December 2, 2013, Tuesday, December 3, 2013 and Tuesday, December 10, 2013 to receive public testimony on these proposed rules. This register summarizes public comment and testimony and the Human Services Department's (Department) response by individual rule.

The Department received XX written comments, XX oral testimonies and no recorded comments.

8.302.2 NMAC, Medicaid General Provider Policies, Billing for Medicaid Services
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.302.2.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.302.2.10.G: In Paragraph (2) one commentator requested further information for providers on rules regarding co-payments.
Department Response: The Department will provide information through its website on the application of co-payments and is will provide assistance to any provider who has questions.

8.302.2.10.G: One commentator noted that many recipients of behavioral health services may take several prescription medications and that charging even modest co-pays for these services and medications could discourage low-income consumers from continuing needed treatment. The commentator suggested that all psychotropic prescription drugs be exempt from co-payments. If co-payments could not be exempted, the commentator requested further clarification on the application of co-payments.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued. The Department will continue to provide guidance on the application of co-payments to providers and recipients.

8.310.2.10.G: One commentator stated that co-payments could become a de-facto rate reduction for providers and that the cost of billing greatly exceeds the value of most co-payments, especially when considering staff-time, IT, postage, and tracking of a somewhat transient population. The commentator encouraged delay of the co-payment portion of Centennial Care.
Department Response: Co-payments are an important aspect to the implementation of Centennial Care. The Department will retain the language as proposed.

8.310.2.10.G: One commentator expressed that a significant portion of "non-emergency" use of emergency services occurs in frontier and rural areas, where there are the most severe shortages of providers, and on weekends, when most providers are not available and said that assessing

these recipients higher cost-sharing than would be assessed in a physician's office is inequitable. The commentator suggested that necessary use of the emergency room be an equal co-payment to a physician visit and that co-payments for unnecessary use of the emergency room for those in CHIP and those over 150% be reduced to $20.
Department Response: Access to available services other than through the emergency department is a criterion considered prior to determining the use of emergency department as unnecessary. However, the Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.302.2.10.G: In Subparagraph (c) of Paragraph (1), one commentator noted that the justifications list for use of a brand name medication is clear, unambiguous and makes sense, but did note the need for some specificity. The commentator suggested that adding "unless the drug item is a brand name psychotropic drug in which case the co-payment does not apply."
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.302.2.10.G: One comment expressed their strong objection to the proposed regulations requiring individuals with incomes under 138% of the federal poverty level to pay co-payments to receive medical services or prescriptions. Research shows that cost-sharing reduces access to care for low-income families who already struggle to make ends meet, especially if a family member has special health needs. Additionally, cost-sharing in Medicaid can worsen the health outcomes for Medicaid recipients. When individuals cannot access preventative care and early treatment, it often means that they use costly emergency room services or let health issues worsen before they final receive treatment.
Department Response: Co-payments are an important aspect to the implementation of Centennial Care. The Department will retain the language as proposed.

8.302.2.11.C: One comment said that the this subsection states that the eligible recipient or authorized representative is responsible for notifying the health care provider of MAD eligibility or pending eligibility and when retroactive eligibility has been established. The commentator requested further information on how this responsibility would be communicated to the recipient or potential recipient.
Department Response: The Department respectfully directs the commentator to the New Mexico Administrative Code rules on eligibility, specifically Part 400 of the individual Eligibility category chapters.

8.302.2.11.G: One commentator asked that the Department outline where the recipient is informed of the fact that he or she cannot be billed when the provider did not file in a timely manner or use proper billing protocol.
Department Response: The Department attempts to make recipients aware of their rights and providers aware of their responsibilities. Typically, a recipient does not expect to be billed for a service usually covered by Medicaid. MAD often receives calls from recipients on why a provider is expecting payment from the recipient. MAD contacts the provider and works with the recipient to resolve the issue.

8.3208.2.12: One comment stated that in cases of dual eligibility, Medicaid has required a client to get a "Medicare denial" before being willing to pay for the service as the insurer of last resort. It was extraordinarily difficult for clients to get that documentation and to assure access to health care. The commentator believes that after "subject to Medicaid reimbursement limitations" it should state "If the medically necessary service is excluded from Medicare and it is a Medicaid covered service, MAD will pay for service."
Department Response: The Department has added this language to the rule.

8.310.2 NMAC, Health Care Professional Services, General Benefit Description
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.310.2.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.310.2.11: One commentator requested clarification on the expectations of the MCO to follow the list of services, limitations and restrictions and which supersedes if there is a conflict between the general benefit rule and the MCO's.
Department Response: The MCO must cover the benefits in this rule, but may do so using different service delivery methods.

8.310.2.11.R: One commentator requested that the current limitation of smoking cessation services to recipients under 21 years of age and pregnant women be lifted since offering broader access to smoking cessation programs would improve the health of all recipients.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.310.2.12.C: One commentator requested that a Physician Assistant (PA) be included as a provider, under the supervision of a physician, who can order laboratory and diagnostic imaging.
Department Response: The Department has included Physician Assistant in this section.

8.310.2.12.I: One commentator requested that a Physician Assistant (PA) be included as a provider, under the supervision of a physician, of routine foot care.
Department Response: The Department has included Physician Assistant in this section.

8.310.2.12.M: One commentator requested that definitions of Telemedicine System and Telemedicine Event be included in the rule.
Department Response: The Department declines to add these definitions, but has edited Subsection M for more clarity on telemedicine services.

8.310.2.12.P: One commentator requested that Family Support Services, Recovery Services and Behavioral Health Respite be included in this rule.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.310.2.13.B: One comment asked that a provision be added that a provider may not charge a Native American under CHIP or WDI, even for a missed appointment.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued. The Department will retain the language as proposed.

8.310.2.14.A: One commentator requested clarification on Paragraph (5).
Department Response: The Department has changed the language: "(5) Reconsideration: A provider who disagrees with a prior authorization-request denial [~~and~~] or another review decision can request reconsideration; see 8.350.2 NMAC.

8.310.3 NMAC, Health Care Professional Services, Professional Providers, Services and Reimbursement
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.310.3.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.310.3.11.C: One comment stated that excluding PAs from assisting at surgery may exacerbate the shortages creating unnecessary delays in a patient's care, which can lead to increased medical emergencies and decreased patient satisfaction. The ability of physicians to utilize PAs in surgery permits physicians to allocate their time to complex procedures and increases the number of patients who receive care. This process creates efficiencies in medical practice which solves or reduces the barriers to a patient's care. The commentator requested that in Paragraph (3), a Physician Assistant (PA) be included as a surgical assistant, under the supervision of a physician.
Department Response: The Department has included Physician Assistant in this paragraph.

8.310.3.11.C: In Paragraph (6), one commentator requested that a Physician Assistant (PA) be included as a provider who could provide nutritional counseling services during an office visit.
Department Response: The Department has changed this paragraph to include physician assistants.

8.310.3.11.E: In Paragraph (1), one commentator requested that Physician Assistant (PA) be added.
Department Response: The Department will retain the language as proposed.

8.310.12 NMAC, Health Care Professional Services, Indian Health Services and Tribal 638 Facilities

The Department will promulgate the final version of this rule at a later time.

8.320.2 NMAC, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Summary of Comments:

General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.

Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.320.2.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.

Department Response: The Department will retain the language as proposed.

8.320.2.15: One commentator noted that the total number of screenings from birth to twenty-one is capped at twenty-five and expressed concern that the lack of flexibility in screening services could be problematic for participants with extensive medical needs. Many persons with disabilities have diagnoses that cause extensive and quickly changing medical difficulties. Individuals in that situation may need more than twenty-five screenings to assess their medical needs, and their quickly changing needs may not adhere to the schedule set forth in the rule.

Department Response: The Department notes that the rule already allows for additional screening as documented by a provider. The periodicity schedule is meant as a guideline for reasonable standards.

8.320.2.18: One comment noted that an IEP is limited to school aged children and should be removed from this section.

Department Response: The Department agrees and has made the requested change.

8.320.2.18: One commentator noted that the EPSDT program furnishes eligible recipients with PCS services to aid them in the completion of activities of daily living the commentator commends to Department for providing this vital assistance to EPSDT participants. However, the commentator further noted that in Paragraph (2) of Subsection A, family members cannot be the one to provide a recipient with PCS and the commentator objected to this limitation.

Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.320.6 NMAC, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, School Based Services for MAP Eligible Recipients Under Twenty-One Years of Age

Summary of Comments:

General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.320.6.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.3206.11: One commentator noted that the previous rule included licensed clinical counselors and licensed family therapists that are now are excluded from the proposed regulation.
Department Response: The Department noted that this rule was unchanged from the previous rule and that both LPCC and LMFT are included in the rule as providers. The Department will retain the language as proposed.

8.320.6.13.C and 8.320.6.15.H: One commentator stated that transportation services must not be restricted in either of these subsections.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.320.6.13.F: One commentator requested that the rule include a statement directing schools to accommodate those who cannot see, hear or read.
Department Response: The Department expects schools to follow the federal requirements. The Department will retain the language as proposed.

8.320.6.14: One commentator stated that the proposed regulation says that an individual's Individualized treatment plan ("ITP") should be created in conjunction with input from the recipient, his or her family and their service providers. The commentator requested that the term "legal guardian" be added to the list of parties providing input for an ITP.
Department Response: The Department notes that "legal guardian" is included in Subsection C: "The ITP is a plan of care agreed upon by the MAP eligible recipient, his or her parents or legal guardians, the evaluating therapists, the IEP or IFSP committee, and the MAP eligible recipient's teacher, all of whom are included in the IEP or IFSP."

8.320.6.15.A: One commentator requested that a Physician Assistant (PA) be included as a provider in a school-based setting.
Department Response: The Department will retain the language as proposed.

8.321.2 NMAC, Specialized Behavioral Health Services, Specialized Behavioral Health Provider Enrollment and Reimbursement
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

General Comment: One commentator stated that in general the proposed rules place overwhelming onus on the providers.
Department Response: There are several methods available for providers to obtain information.

General Comment: Two commentators noted their support in including ABA benefits in this rule. One of the commentators urged the state to design the service as a competitive line of business. Another commentator provided guidelines from the Behavior Analyst Board to inform decisions about ABA implementation and delivery.
Department Response: The Department appreciates the support and information and will continue to study this and if, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.7: One commentator requested clarification on the meaning of "[RESERVED]".
Department Response: The Department generally defines a term within a section or subsection of a rule only where necessary.

8.321.2.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed. One commentator further noted that the rule did not meet the stated mission.
Department Response: The Department will retain the language as proposed.

8.321.2.9: One commentator noted that the restriction on LMHC's would be detrimental to recipients.
Department Response: The proposed rule does not differ from the current rule pertaining to the provider types that are eligible to be reimbursed for specific services rendered by a Medical Assistance Division (MAD) non-independently licensed behavioral health practitioner. This restriction applies to services provided through the Fee-for-Service System. Managed care organizations have more latitude in covering the services of these providers.

8.321.2.9.A: One commentator stated that this rule would reduce the variety and number of providers and provider groups and would allow denial of claims due to ambiguity in the definitions of "Agencies, Provider Groups, Mental Health Centers, Mental Health Agencies."
Department Response: Information for providers is provided online as well in hard copy format. The Department would ask that the commentator contact the department directly for any specific information on provider policies.

8.321.2.9.B: One commentator noted that the current and proposed regulations disregard the rights and privileges of "scope of practice," granted licensed behavioral health professionals by the State's own Regulations and Licensing Department, Boards and Commissions.
Department Response: This rule is stating a limitation that services outside scope of practice cannot be covered.

8.321.2.9.C: Two commentators noted that personality disorders for anyone are a non-covered service as outline in Paragraph (4).

Department Response: The Department has changed the language in Paragraph (4) to say: "treatment for personality disorders for adults 21 years and older without a diagnosis indicating medical necessity for treatment."

8.321.2.9.C: One commentator requested that language prohibiting residential treatment for substance abuse for adults be clarified, stating that it should be restored to "residential centers."
Department Response: The rule was referring to residential centers. The requested change has been made.

8.321.2.9.E: Three commentators expressed concern with the disallowance of non-independently licensed therapists. One commentator noted that the proposed rule would make it impossible them to provide service to their current population because they would no longer be allowed to use non-independently licensed therapists stating that it is difficult to find qualified candidates. One commentator noted that disallowance limits the number of eligible providers for both the short and long term. One commentator noted that the proposed rule would have a long term negative impact on the residents of Los Alamos County and all other remote/rural New Mexico communities.
Department Response: The proposed rule does not differ from the current rule pertaining to the provider types that are eligible to be reimbursed for specific services rendered by a non-independently licensed behavioral health practitioner. This restriction applies to services provided through the Fee-for-Service System. Managed care organizations have more latitude in covering the services of these providers.

8.321.02.9.H: One commentator noted that the term "the groups they form" is an unclear term and suggested that the use of "practitioner groups" would be cleaner.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.9.H: In Paragraph (1), one commentator requested that physician assistants be included.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.9.I: One commentator stated that limiting the variety of agencies where non-independently licensed clinicians may perform behavioral health services under supervision further perpetuates the shortage of service availability. In addition it further retards the development of independently licensed clinicians in the State. The commentator also noted that a Community Mental Health Center (CMHC) has no apparent definition.
Department Response: This limitation applies to services provided through the Fee-for-Service System. Managed care organizations have more latitude in covering the services of these providers. The term Community Mental Health Center is defined by the entity that licenses them.

8.321.2.9.J: One commentator noted that Certified Peer Support Workers and Certified Family Support provide essential services that are currently reimbursable by Core Service Agencies and other public providers and that they should be included in the list of reimbursable agency-based providers.

Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.10: One commentator noted their appreciation that ABA services are part of the Medicaid service package. The commentator further noted that there are significant limitations placed on the provision of ABA. The commentator noted that EPSDT provisions of Medicaid apply to this and all Medicaid services for MAP eligible recipients under age 21 yet, the Department is proposing that only children who need ABA in conjunction with another therapy or service will be provided ABA interventions. Also, by delineating which children will be provided with ABA, the Department is prescribing treatment, which is a clinical, not regulatory function.
Another commentator asked if placement of ABA services in the behavioral health section of rule meant that costs for ABA Services will be counted in a MCO's behavioral health service spending? The commentator also asked if providers of ABA services be included in the list of providers eligible and should the rule address the qualification of those providers? The commentator also asked if the relationship between ABA services and other Medicaid and educational services the child receives be clarified.
Another commentator requested that clinicians with experience in ACA and who possess a Master's degree and have a well-documented history of being able to provide quality clinical supervisions for ASB be included.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.10: One commentator noted that the current 0-5 Medicaid ASB program bundles as services into one rate and requested that the services be paid at an hourly rate. The commentator also requested that MAD-required supervision services should be included as reimbursable activities, including indirect and direct supervision.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.10: One commentator requested that independently licensed Master's level clinicians be allowed to serve as supervisors for the ASB Medicaid program and not restrict that supervision to Board Certified Behavior Analysts (BCBAs).
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.10: One commentator requested that Medicaid should reimburse ABA agencies for supervision and treatment planning/treatment assessment associated with the provision of ABA services, including for the provision of 1-hour of supervision per week and for 2-hours per week of treatment planning.
Department Response: The Department recognizes for ABA to be highly effective, intensive supervision of the delivery of the service is necessary. This factor will be taken into account in the billing instructions.

8.321.2.11.B: One commentator requested clarification of the term "accommodation service."

Department Response: "Accommodation service" refers to the room and board costs and is something that would be covered as part of ARTC.

8.321.2.11.D: One commentator requested clarification of the "the following" that did not include a list.
Department Response: This has been changed for clarity.

8.321.2.11.F: In Subsubpargraph (i) of Subpargraph (c) of Paragraph (1), one commentator asked why "room and board" was included as a non-covered service and for clarity on the coordination of the educational program of the child.
Department Response: "Room and board" has been removed and coordination with the education program has been noted in the rule.

8.321.2.12: One commentator noted that this was an excellent service model which they hoped MCOs would expand in the coming years.
Department Response: The Department appreciates the support.

8.321.2.13.D: One commentator noted in Paragraph (3) that the subpart may be technically correct. However, Medicaid in the Schools still exists and Medicaid may pay for these services through disbursement to schools rather than to participating Medicaid community providers.
Department Response: If the school is providing the services, the school will be providing these services and the Department does not need to outline this fact in the rule. The language will be retained as proposed.

8.321.2.14: One commentator asked if the eligible population for Comprehensive Community Support Services should be expanded to include adults with chronic substance abuse.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.14.A: One commentator expressed concern that there may not be one of the specified agencies close enough to serve rural and frontier communities, leaving open the question of whether the MCO networks will be adequate to provide these services in a timely fashion. To assure network adequacy, MCOs should be able to contract with small agencies in rural and frontier areas to provide CCSS services in their communities. In addition, this is a circumstance in which smaller local agencies may likely provide more culturally competent services than the larger agencies can. The commentator strongly recommended that the rule be amended to permit small agencies to provide CCSS services in rural and frontier communities. The commentator also suggested that credential to be a CSW be included and that providers outlined in Subparagraph (d) be certified or obtain a certificate on the job within the first year to get some formal training.
Department Response: The Department will work with the MCOs to ensure that eligible CCSS providers are providing services in rural and frontier communities and providing culturally competent services.

8.321.2.14.A: One commentator noted that the continuing education requirement is only applicable to Peer/Family Support Workers.

Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.14.C: One commentator noted that this rule states that "limited CCSS services may be provided during discharge…" and requested clarification on what the limitations were.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.14.D: One commentator noted that this rule says nothing about a person with a dual diagnosis of SMI, and developmental disability SMI and TBI. Do these other diagnoses preclude a person from receiving CCSS?
Department Response: If an individual is SMI, he or she meets CCSS target population requirements. DD and TBI are factors that a recipient's treatment team would take into consideration when developing a service plan.

8.321.2.15: One commentator noted that this section should address that a child is entitled to an education while receiving day treatment and that the program must coordinate with the school program.
Department Response: "Educational programs other than those indicated above" will be added for clarity.

8.321.2.15: This section includes two references to BMS which should reference Day Treatment.
Department Response: The requested changes have been made.

8.321.2.16: Two commentators strongly recommended that services in freestanding psychiatric hospitals for MAP eligible recipients 21 years of age or older continue to be covered.
Department Response: This is a Federal limitation and applies to the Fee-for-Service program. Managed care organizations have more latitude in coverage.

8.321.2.16.C: One commentator noted that the inpatient care should coordinate with educational services.
Department Response: "Educational programs other than those indicated above" has been added for clarity.

8.321.2.16.F: One commentatory noted that this section states that discharge must not be delayed because post-hospital planning is neglected.
Department Response: This sentence has been removed as requested.

8.321.2.17: One commentator asked if the provisions related to Intensive Outpatient Programs (IOP) be modified to provide CYFD have authority to regulate IOP programs that serve youth under 18 and ensure youth are not transitioned to adult services against clinical judgment.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.17.A: One commentator requested an explanation of the inclusion of the rural health clinic (RHC) in this section.
Department Response: A rural health clinic can bill and be paid for services for which all requirements for providing the service are met.

8.321.2.19.C and 8.321.2.19.D: One commentator noted that the MST staff should coordinate with educational services for a young person's school.
Department Response: "Educational programs other than those indicated above" has been added for clarity.

8.321.2.20.B: Once commentator noted that if "accommodation" is meant to mean room and board that should be made clear.
Department Response: The language has been changed for clarity.

8.321.2.20.C and 8.321.2.20.F: One commentator stated that room and board are designated as non-covered services in this section.
Department Response: The Federal rules permit payment of accommodation charges in accredited RTC's but not for RTC's that are not accredited.

8.321.2.21.D: One commentator said that in this Section, Medicaid is not paying for transportation for outpatient or partial hospitalization programs.
Department Response: Covered transportation to and from the services are reimbursed per the transportation rules in 8.324.7 NMAC. Transportation that may occur during the partial hospitalization service is covered as part of the service.

8.321.2.23: One commentator noted their support of the goal of psychosocial rehabilitation services, but also reminded that medically necessary services are provided not only to attain or regain functional capacity, they are also provided to maintain functional capacity.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.23: One commentator asked if the provisions related to psychosocial rehabilitation be updated and modernized.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.23.B: One commentator said that the rule states PSR programs must comply with DOH mental health standards and asked for specificity on the DOH standards to which PSR providers must comply. The commentator also noted that the services would be limited to goal oriented services to restore the recipient to his or her best possible level of functioning and reminded the Department that this could be possible that the level of functioning for the individual to maintain is their current level of functioning.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.321.2.25.C: One commentator noted that room and board is included as a noncovered service.

Department Response: Room and board that may occur during the services is covered as part of the service. The Department will retain the language as proposed.

8.324.4 NMAC, Adjunct Services, Pharmacy Services, Prescribing and Practitioner Administered Drug Items

Summary of Comments:

General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.

Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.324.4.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.

Department Response: The Department will retain the language as proposed.

8.324.4.12 and 8.324.4.15: Two commentators asked if there should be an exemption for Generic First and Step Therapy requirements for psychotropic medications.

Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.324.4.12.A: One commentator stated that this proposed rule significantly restricts Medicaid recipients from obtaining over-the-counter items and that the rule does not provide for exceptions based on medical necessity.

Department Response: The intent of the rule is to allow the recipient to purchase most over the counter drugs unless for chronic use. This is essentially how the existing rule works, with coverage of OTC items being broad.

8.324.4.12.B: One commentator states that the generics-first provision does not apply to injectable drugs and asked if this should be removed.

Department Response: While a provider may use a generic item first, there is no requirement to do so. The Department will retain the language as proposed.

8.324.4.13.B: One commentator asked if MAD would be providing a list of rebate requirements to the MCO's or if MAD follows the CMS published list.

Department Response: The Department follows the CMS published list.

8.324.4.14.A: One commentator stated that the restrictions listed in proposed Paragraphs (5), (8), (9), (11), (12), and (13) require the same exceptions for medical necessity and a reasonable modification under the ADA. The commentator also requested that language be added to Pargraphs (5), (11), and (12) to bring them into conformity with federal law, by stating that a medication cannot be excluded simply because the FDA has not approved the medication or its use for the recipient's condition.

Department Response: The intent is not to limit drug items to only FDA-approved uses, but before deciding on any specific changes in language the Department would need to study further

and if, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.324.4.14.A: One commentator asked if the exclusion cosmetic items applied to the diagnosis of acne or actinic keratosis.
Department Response: The Department clarifies, that no, but they would not be considered cosmetic items either.

8.324.4.14.C: One commentator noted that the rule clearly states that Medicaid will pay for medications excluded under Medicare part D. The commentator went on to say that is often difficult to get the Medicare denial and asked that the rule be amended to put the responsibility on the MCO to secure the Medicare coverage determination.
Department Response: Because of Point-of-Sale systems, the status of a Medicare payment is known virtually immediately to the pharmacist. Medicare coverage criteria is well-known, so determinations can be made quickly.

8.324.4.17: One commentator stated that the rule asks the pharmacist to be responsible for resolving the point of sale issue and obtaining an authorization to dispense the drug if necessary. The commentator went on to state that this function should reside with the prescriber.
Department Response: When the pharmacist receives a denial they can ask the recipient for clarification and can contact the payor. This is a common role for the pharmacist.

8.324.5 NMAC, Adjunct Services, Vision Appliances, Hearing Appliances, Durable Medical Equipment, Oxygen, Medical Supplies, Prosthetics and Orthotics
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

General Comment: One commentator stated that medical necessity is not considered in these regulations and the proposed rules should clearly state that an exception shall be made in an individual case based on medical necessity.
Department Response: The Department believes that DME meets medical necessity criteria. The Department tries not to list covered items to allow for medical necessity which is accomplished through the prior-authorization process.

8.324.5.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.324.7 NMAC, Adjunct Services, Transportation and Lodging Services
Summary of Comments:

General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.324.7.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.324.7.10: One commentator noted that the MAD needs to make documents available in both electronic and hard copy formats.
Department Response: The language has been changed for clarity.

8.324.7.12.A: One commentator stated that the meaning of the last sentence in this subsection is unclear and that participants cannot be expected to know how to submit a certified written document.
Department Response: The Department has removed the last sentence as requested.

8.324.7.12.J: One commentator stated that the limitation of transportation for waiver recipients to therapy or a behavioral health service is illegal and that many waiver participants require transportation to services other than therapies.
Department Response: The Department notes that this restriction that has been determined by CMS. Transportation to a waiver provider can only be covered by waiver services.

8.324.7.13.C: One commentator said there no reason for this prohibition on transportation to a pharmacy and that the reference to 8.310.2 NMAC is unhelpful and clarifies nothing.
Department Response: The language has been changed for clarity. Transportation is not provided unless other services, such as free delivery, have been exhausted. The Department also notes that retail pharmacies may ship as noted in 8.324.4 NMAC.

8.351.2 NMAC, Sanctions and Remedies, Sanctions and Remedies
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

General Comment: One commentator expressed concern about how the proposed sanctions may impact persons with disabilities who need the services of the providers and the MCOs. The commentator strongly suggested that language be added to this section to insure that if HSD imposes sanctions in the future, HSD will take all reasonable steps to insure the continued delivery of the proper level of service to the plan participants.
Department Response: The Department is following federal requirements.

8.351.2.8: Two commentators stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.351.2.10: One commentator noted that this section says that MAD "is required" to impose sanctions.
Department Response: The Department has changed the word "required" to "may" to clarify language.
8.351.2.11: One commentator noted that this section says that MAD "is required" to impose sanctions.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.351.2.12: One commentator noted that this section says that MAD "is required" to impose sanctions.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.351.2.14.B: One commentator stated that this section denies the provider or MCO accused of a credible allegation of fraud from having an administrative hearing; a provider or MCO accused of neglect, abuse or poor medical care of the participants is permitted an administrative hearing but those accused of fraud are not and the department provides no reason why fraud is more important than a substandard level of care provided to plan participants.
Department Response: The Department is following federal requirements. The language will be retained as proposed.

8.352.2 NMAC, Administrative Hearings, Claimant Hearings
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

8.352.2.7 and 8.352.2.9: One commentator stated that the proposed rule that only allows a court appointed individual to request a hearing and act in a fair hearing on behalf of a Medicaid recipient is untenable. The proposal prevents a power of attorney duly appointed by the member from participating in the hearing for the member.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.7.B: One commentator stated that the proposed definition of "authorized representative" is incorrect and that the "representative" is of the applicant's or beneficiary's choosing, not of the choosing of an "appropriate court" uninvolved with the administrative hearing.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.8: One commentator stated that the Department's mission statement is offensive and requests that the language be changed.
Department Response: The Department will retain the language as proposed.

8.352.2.10: Two commentators stated that the definition of "adverse action" was unnecessariliy limiting and further stated that an adverse action should be defined as "allowing for an administrative hearing is any termination, modification, reduction, suspension, denial, or other decision the claimant believes to be erroneous."
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.11: Two commentators noted that the proposed rule adopts a fair hearing system that requires Medicaid recipients enrolled in a managed care organization to exhaust their MCO appeal first, before they can file for a fair hearing.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.11: One commentator noted that the proposed rule did not take into account when a Medicaid recipient needs to request a fair hearing if ISD has taken an adverse action against him or her. There are circumstances when an individual receiving Medicaid benefits (whether enrolled in a MCO or not) is subject to an adverse action from ISD.
Department Response: This right to a hearing is found in ISD rules.

8.352.2.11.C: Three commentators noted that the rule states that the claimant has 90 calendar days of his or her MCO's final decision to request a HSD administrative hearing. However, the MCO contract states the member has 30 days in which to file a hearing from the date of the MCO's final decision.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.13: Two commentators noted that the proposed rule requires that the Medicaid recipient call one place to request a fair hearing (Fair Hearings Bureau or ISD) and call another place to request continuation of benefits (MAD UR Contractor). Requiring Medicaid recipients to call two different places to ensure that they have requested a fair hearing and asked for continuation of benefits may confuse many people and lead them to make mistakes. The system should remain as it is, with Medicaid recipients permitted to contact the Fair Hearings Bureau to request their hearing and ask for continued benefits.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.14: One commentator requested clarification between the proposed informal resolution conference and the proposed pre-hearing conference.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.15: One commentator noted that the prehearing conference in the proposed rule is too complicated for the Medicaid recipient who is unrepresented by an attorney and that many unrepresented Medicaid recipients are not going to be able to understand stipulations and admissions, or to prepare written summaries of issues resolved at the hearing, or to draft prehearing orders or points of law.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.15: One commentator stated that the proposal is to make the Department's Summary of Evidence a flexible work in progress. HSD describes the SOE as providing "preliminary information concerning the basis of its, its contractor or the HSD MCO's action" and allows MAD to amend the SOE prior to the pre-hearing conference. This proposal gives the Department leeway to take adverse action against a Medicaid recipient without first having all the information it needs to make the decision, and then justifying the decision after the fact.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.15: One commentator noted that the claimant may have documents to support his position, but the claimant's evidence is not the same as a summary of evidence and that the time frame for the Department producing the summary of evidence and the Medicaid recipient submitting his documentary evidence puts the Medicaid recipient in an impossible situation. The commentator stated that while the adverse action notice is supposed to provide the reasons for the adverse action and cite to the regulations on which the adverse action is based, historically adverse action notices do not provide sufficient information to understand the reason for the adverse action and the first time the Medicaid recipient is provided the specific reason for the adverse action is when the recipient receives the summary of evidence. The Medicaid recipient cannot put together evidence challenging the Department's case without first having seen the summary of evidence. Therefore, requiring the Department and the Medicaid recipient to produce their evidence on the same day leaves the Medicaid recipient no opportunity to actually review MAD's summary of evidence before having to provide his own documentary evidence to the ALJ. The Medicaid recipient will be operating in the dark, guessing what evidence is contained in MAD's SOE, and the proposed regulations allow ALJ to punish the Medicaid recipient for not having produced evidence by the deadline. The Medicaid recipient must have a reasonable opportunity to review MAD's summary of evidence prior to being required to submit his own documentary evidence to the ALJ.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.15: One commentator stated that the proposed rule does not clarify what it means by "would not otherwise have an opportunity to challenge or contest." The Department should not be allowed to introduce evidence that it did not provide the Medicaid recipient in the summary of evidence within a reasonable time before the hearing, nor should the hearing office be able to rely on such evidence to make a recommended decision.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.16: One commentator asked if the the ALJ participate in the pre-hearing conference and how this differs from the informal resolution conference.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.16.F: One commentator noted that the final sentence of the introductory paragraph needs to clarify the deadline for the provision of the amended SOE. We do not see the need for an amended SOE. HSD and/or its contractors already have all documents necessary for the SOE at the time of the adverse action. However, if this amended SOE will be permitted, this introductory paragraph should state that an amended SOE will only be permitted with good cause and under extraordinary circumstances.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.16.G: One commentator stated that the 10-day deadline in advance of a hearing for the claimant to present evidence is illegal and the deadline would be completely unnecessary, and violate due process. Claimants have to scramble and hustle to compile evidence to respond to the SOE, and frequently must schedule a medical appointment and then receive records after that appointment. Claimants often do not have the opportunity to get all their evidence together so far before the hearing.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.16.H: One commentator noted that the proposed rules are far too limiting with regards to the information to be provided to the claimant and further pointed out that the rules must be amended to clarify that the claimant has the right to see any and all documents in his or her HSD and contractor case files.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.17: One commentator stated that the hearing record should consist of pleadings, documents, or other exhibits offered to the hearing officer for consideration, not just those 'admitted into evidence.' First, the fair hearing is not a formal evidentiary proceeding and the rules of evidence do not apply, so a document is not 'admitted into evidence.' Second, rejected exhibits must be retained in the record. The record must include the evidence proffered to the hearing officer even if the hearing officer decided not to allow or consider the evidence, so that if the case is appealed, the district court has what offered.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.17.D: One commentator noted that in Pargraph (1) it is required that the ALJ admit evidence that is relevant to the contemplated action or the action taken by HSD. The ALJ should not allow evidence produced by the Department that is not provided to the Medicaid recipient in the summary of evidence within a reasonable time prior to the hearing nor should the ALJ rely on such evidence in making a decision.

Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.17.A: One commentator noted that the ALJ should consider and make recommendations based on all relevant state and federal statutes, rules and regulations.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.17.C: One commentator stated that this section needs to be re-written as it includes two references to the "claimant's SOE." And no such "claimant's SOE" exists, and any reference to it throughout the rules would be incorrect. The SOE is the HSD evidence in support of the adverse action; the claimant's evidence is not an SOE.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.21: One commentator stated that the proposed rule does not do enough to correct the inequitable situation that results from an erroneous adverse action taken by HSD, the MCO, or UR contractor and further stated that HSD must develop a system to directly reimburse Medicaid recipients who incurred out of pocket expenses for Medicaid covered services when they were inappropriately denied Medicaid.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.2.21.A: One commentator stated that the sentence"If the hearing decision... will start collection proceedings" needs to be changed to "...may start collection proceedings." The commentator stated that it would be improper to put anything in the rules that seems to require collection proceedings. Many participants have no collectable assets or income, and it would be waste of valuable Medicaid resources to start collection proceedings in every case of a decision favorable to HSD or its contractors after continued benefits.
Department Response: The Department will consider the comment further. If, after further study, it appears a change needs to be made, a new proposed rule will be issued.

8.352.3 NMAC, Administrative Hearings, Provider Hearings
Summary of Comments:
General Comment: All of the commentators noted typographical errors, mis-numberings and other general edits.
Department Response: The Department appreciates the comments and has made corrections for clarity and consistency.

VI. RULES

The rules referenced above will be contained in the Medical Assistance Division (MAD) New Mexico Administrative Code (NMAC) Rule Manual and are available on the MAD website

http://www.hsd.state.nm.us/mad/RPolicyManual.html . If you do not have internet access, a copy of the rules may be requested by contacting MAD at 505-827-3152.

EFFECTIVE DATE:

The Department will implement these rules effective January 1, 2014.

VIII. PUBLICATION

Publication of these rules approved by:

SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT