State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT

NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT

PROPOSED AMENDMENTS TO RULES RELATED TO THE MEDICAID MANAGED CARE PROGRAM AND MEDICAID GENERAL PROVIDER POLICES RELATED TO THIRD PARTY LIABILITY

III. PROGRAM AFFECTED

(TITLE XIX) MEDICAID

IV. ACTION

PROPOSED RULE AMENDMENTS

V. BACKGROUND SUMMARY

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to amend the following NMAC rules.

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

These changes are being proposed to match the requirements of federal rules. The Centers for Medicare and Medicaid Services (CMS) published federal rules, effective July 5, 2016, that updated Medicaid managed care requirements which the Department must now implement. The federal rules align the requirements governing Medicaid managed care programs, where feasible,

with those of other major sources of health care coverage, including Qualified Health Plans and Medicare Advantage plans. The citation for the federal rule is 42 CFR 438 subparts A through J.

MAD reviewed the current rules related to managed care to assure they will be in compliance with federal requirements. They were also reviewed for currency and clarity. Necessary changes are being proposed as amendments to the existing managed care organizations (MCO) rules listed above. Also, amendments are being proposed to 8.302.2 NMAC, Medicaid General Provider Policies, Third Party Liability Provider Responsibilities, because of its relationship to managed care organizations. NM Statute Section 9-8-6 (2016) authorizes the Department Secretary to promulgate rules and regulations that may be necessary to carry out the duties of the Department and its divisions.

The amendments will implement new statutory provisions related to member rights and grievance and appeal processes. They strengthen actuarially sound payment provisions to promote the accountability of Medicaid managed care program rates. They also contain several provisions to promote the quality of care and strengthen the health care delivery systems that serve Medicaid and Children's Health Insurance Program members enrolled with managed care organizations (MCOs). The new rules ensure specific beneficiary protections and include policies related to program integrity efforts.

In each proposed rule, Section 8: "Mission Statement" was deleted and this section is now reserved. This change has no effect on any administrative or programmatic functions. The change is being made to be consistent with other program rules.

Also, grammatical errors, typographical errors, and reference citations are corrected as indicated in the proposed rules.

The Department proposes to amend rules as follows:

8.308.2 NMAC MANAGED CARE PROGRAM – PROVIDER NETWORK

Section 9: Adds clarifications and new responsibilities to provider enrollment requirements to meet federal requirements and to assure consistency between MCO provider records and MAD provider records.

Section 11, Subsection D: New wording adds provider access standards to the rule.

Section 12, Subsection C: For dental access standards, "consistent with community norms for dental appointments" was replaced with "no more than sixty (60) calendar days unless the member requests a later date." **Subsections L and R:** Adds access standards for pharmacy and behavioral health crisis services, respectively.

Section 15: Adds a new section regarding MCOs contracting with Indian health service, tribally operated facilities, and urban Indian clinics (I/T/Us); and re-numbers the remainder of this section.

Section 16: Adds standards for MCOs regarding credentialing providers.
No proposed changes in this rule will limit services or eligibility, or otherwise negatively impact managed care members.

8.308.6 NMAC MANAGED CARE PROGRAM - ELIGIBILITY

Section 9, Subsections B and C: Corrects the list of Medicaid recipient categories that are not enrolled in managed care. This is a correction only and does not change who is actually enrolled in managed care. Also, wording is changed for better clarity on enrolling Native Americans in managed care. This is also just a wording change and does not change the requirements or process currently in place.

Section 10, Subsection A: Replaces "12 months" with "13 months", pursuant to a federal rule amendment that specifies a newborn is enrolled for 13 months starting with the month of birth.

8.308.7 NMAC MANAGED CARE PROGRAM – ENROLLMENT AND DISENROLLMENT

Section 9, Subsections C, D, and E: Changes the auto assignment eligibility period from two months to six months or less. Includes language clarifying the retroactive span of eligibility considered for enrollment in managed care "to not to exceed two years" and deleted references to time periods prior to January 1, 2014. Changes all enrollment time periods that were previously "90 days" to "three months" since applicable time periods are always calculated in months rather than in days. Adds language clarifying member enrollment periods prior to changing MCOs.

The loss of eligibility period followed by re-instated eligibility resulting in re-assignment to the previous MCO was increased from two months to six months. The period during which a member may select a different MCO following reassignment to the prior MCO was increased to three months. It was previously two months.

Section 12: The time period for issuance of a member identification card by an MCO is changed to 20 calendar days following notification of enrollment. This time period was previously 30 days.

8.308.8 NMAC MANAGED CARE – MEMBER EDUCATION

Part 8 Title: Amended to read "Member Rights, Responsibilities, and Education

Language was added throughout to assure that MCOs comply with federal requirements with regard to supplying informational and educational materials to members and for the civil rights and other rights that MCOs are required to provide to members of an MCO.

8.308.9 NMAC MANAGED CARE – BENEFIT PACKAGE

Section 10: Language was added to assure MCOs follow federal requirements regarding providing benefits, citing applicable federal citations.

Section 11: Added language to require that MCOs meet all behavioral health parity requirements.

Section 12: Added new benefit item (L), health home services and re-lettered the remainder of this section. This benefit is added to the rule for completeness and clarification because the services are already being provided. Wording was added to distinguish between home health services in the home and other services provided in the home. Wording was added to physical health benefits to include birth center benefits and licensed birthing center benefits and other covered delivery services.

Also, clarification is added that routine vision care is not a benefit for a member 21 years and older whose eligibility is as an Alternative Benefit Plan beneficiary. Previously the rule stated that one routine eye exam per member was allowed every 36 months. This change is consistent with the federal requirements regarding Alternative Benefit Plan coverage.

Section 14: Added additional information for clarity regarding the MCOs' responsibility to cover pharmacy services.

Section 16: Added new wording for clarity regarding the MCOs' responsibility to cover plan B and long acting reversible contraception items.

Section 19, Subsection A: Included crisis services and opioid treatment programs as behavioral health services that MCOs are to cover.

In this section, information stating to "See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines–respite services-for a detailed description" was deleted.

Section 24: This new section incorporates wording from the federal rule on emergency services and stabilization to assure a member has adequate care during an emergency situation.

Section 25: This a new section incorporates wording from the federal rule related to coverage of services with regard to medical necessity, authorization requirements, and comparability to fee-for-service Medicaid coverage. This section generally assures the MCO provides necessary services to members.

8.308.10 NMAC MANAGED CARE PROGRAM – CARE COORDINATION

Section 9: Adds language to clarify the MCO requirement to employ or contract with a Native American care coordinator or contract with a community health representative to serve as a care coordinator.

8.308.11 NMAC MANAGED CARE PROGRAM – TRANSITION OF CARE

Section 9: Adds information clarifying the circumstances under which a member will be provided care coordination. **Subsection D:** Adds information regarding MCO identification of members who transition from institutional care to the community.

8.308.13 NMAC MANAGED CARE PROGRAM – MEMBER REWARDS

Section 9: Added clarifying language that a member may participate in a managed care member rewards program.

8.308.15 NMAC MANAGED CARE PROGRAM – GRIEVANCES AND APPEALS

Proposed changes to the rule are intended to assure that the federal requirements regarding grievances and appeals relating to managed care organizations and their members will be followed in the New Mexico Medicaid program. Additional changes are being made for clarity and to assure consistency in how MCOs interpret and conduct the grievance and appeals processes. Specifically:

1. Proposed wording has been added throughout the proposed rule to clarify who may file a grievance or appeal and who may request an administrative hearing, and expanding the extent to which an "authorized provider" may represent a member in the process.

2. Proposed wording was added throughout the rule to clearly differentiate between provider appeals and grievances vs. member appeals and grievances and to differentiate between the requirements for expedited appeals vs. standard appeals.

3. Provisions were added to assure an MCO provides sufficient information to a provider or member to better explain why an adverse action is being taken; seeks additional information from a provider prior to making a final decision; and provides additional information explaining an adverse decision.

Time-Frame Requirements

The grievance and appeal processes are described in the proposed rule. The time frames and deadlines for various actions were reviewed and sometimes changed to comply with the new federal rule or as otherwise deemed appropriate. The term "member", below, means the member, his or her authorized representative or authorized provider when applicable:

1. A provider or a member may file a grievance at any time. Previously, a grievance had to be filed within 30 calendar days of the relevant event triggering the grievance. However, a grievance cannot be filed regarding an adverse benefit determination or the MCOs final grievance decision.

2. An appeal must be filed within 60 calendar days of the notice of adverse action. Previously the time frame was 90 days.

3. A member who is dissatisfied with the appeal decision who chooses to request an HSD administrative hearing must do so within 90 days of the final appeal decision for a standard fair hearing and within 30 days for an expedited administrative hearing.

Section 7, Subsection B – Definitions
The Department is proposing new language in the definitions section, clarifying what constitutes a MCO adverse action against a member. The definition also incorporates the federal definition of Adverse Benefit Determination in order to be compliant with the federal rules. Many other definitions are added or expanded for clarity in order to help all parties involved in the process to have a common understanding of the meaning of the rule.

Subsection E - Authorized Representative: Includes new wording to allow a member's treating provider to act as the member's authorized representative when the member is medically incapacitated or when the member's authorized representative cannot be located, and the member requires immediate medical care until such time as the member appoints an authorized representative or the member's current authorized representative is located.

Section 13 MCO Expedited Member Appeal Process

Subsection E and F: Specifies that the MCO expedited member appeal process must be concluded and a final decision made by the MCO within 72 hours after a request for a MCO expedited appeal is made. There are provisions for extending the time frame when necessary.

Section 14 MCO Standard Member Appeal Process
Subsection A: Requires the MCO standard member appeal process to be concluded and a final decision made by the MCO within 30 calendar days of the request for the appeal. There are provisions for the extending the time frame when necessary.

8.308.21 NMAC MANAGED CARE PROGRAM – QUALITY MANAGEMENT

Sections 9 through 19: Provides additional information and requirements regarding the quality management programs, including additional criteria for mandatory and optional External Quality Review Organization activities.

8.302.3 NMAC

Section 12: Amended the existing rule to clarify when claims must be denied due to the recipient having other insurance resources or third party liability and when claims cannot be denied. The language specifies that MCOs must follow these requirements as established by federal regulation.

VI. REGULATIONS

This proposed rules will be contained in 8.308.2 NMAC; 8.308.6 NMAC; 8.308.7 NMAC; 8.308.8 NMAC; 8.308.9 NMAC; 8.308.10 NMAC; 8.308.11 NMAC; 8.308.13 NMAC; 8.308.15 NMAC; 8.308.21 NMAC; 8.320.2 NMAC; and 8.302.3 NMAC.

The register and proposed rule language are available on the HSD website at: http://www.hsd.state.nm.us/LookingForInformation/registers.aspx and http://www.hsd.state.nm.us/public-notices-proposed-rule-and-waiver-changes-and-opportunities-to-comment.aspx. If you do not have internet access, a copy of the proposed register and rule may be requested by contacting MAD at 505-827-6252.

VII. EFFECTIVE DATE

The Department proposes to implement this rule effective February 1, 2018.

VIII. PUBLIC HEARING

A public hearing to receive testimony on this proposed rule will be held in the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico, on November 20, 2017, from 10 a.m. to 12 p.m., Mountain Standard Time (MST).

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact MAD in Santa Fe at (505) 827-6252. The Department requests at least 10 working days advance notice to provide requested alternative formats and special accommodations.

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

IX. ADDRESS

Interested persons may address written or recorded comments to:

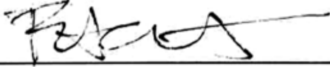
Human Services Department
Office of the Secretary
ATTN: Medical Assistance Division Public Comments
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

Recorded comments may be left at *(505) 827-1337*. Interested persons may also address comments via electronic mail to: madrules@state.nm.us. Written mail, electronic mail and recorded comments must be received no later than 5 p.m. MST on November 20, 2017. Written

and recorded comments will be given the same consideration as oral testimony made at the public hearing.

X. PUBLICATIONS

Publication of this rule approved by:



BRENT EARNEST, SECRETARY
HUMAN SERVICES DEPARTMENT