State of New Mexico
Human Services Department
**Human Services Register**

**I. DEPARTMENT**
HUMAN SERVICES DEPARTMENT

**II. SUBJECT**
8.200.400 GENERAL RECIPIENT RULES-GENERAL MEDICAID ELIGIBILITY
8.201.600 MEDICAID EXTENSION-BENEFIT DETERMINATION
8.215.600 SSI METHODOLOGY-BENEFIT DESCRIPTION
8.231.600 INFANTS OF MOTHERS WHO ARE MEDICAID ELIGIBLE-BENEFIT DESCRIPTION
8.242.600 QUALIFIED DISABLED INDIVIDUALS WHOSE INCOME EXCEEDS QMB AND SLIMB-BENEFIT DESCRIPTION
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8.298.400 LOSS OF PARENT CARETAKER MEDICAID DUE TO EARNINGS FROM EMPLOYMENT-RECIPIENT REQUIREMENTS
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8.299.400 FAMILY PLANNING SERVICES-RECIPIENT REQUIREMENTS
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8.302.2 MEDICAID GENERAL PROVIDER POLICIES-BILLING FOR MEDICAID SERVICES

## III. PROGRAM AFFECTED

(TITLE XIX) MEDICAID

## IV. ACTION

FINAL RULE

## V. BACKGROUND SUMMARY

New Mexico Human Services Register Volume 41, Register 27, dated September 25, 2018, issued the following proposed rules: *8.200.400 General Recipient Rules-General Medicaid Eligibility; 8.201.600 Medicaid Extension-Benefit Determination; 8.215.600 SSI Methodology-Benefit Description; 8.231.600 Infants Of Mothers Who Are Medicaid Eligible-Benefit Description; 8.242.600 Qualified Disabled Individuals Whose Income Exceeds QMB And SLIMB-Benefit Description; 8.243.400 Working Disabled Individuals-Recipient Policies; 8.243.600 Working Disabled Individuals-Benefit Description; 8.245.600 Specified Low Income Medicare Beneficiaries-Benefit Description; 8.249.600 Refugee Medical Assistance-Benefit Description; 8.250.600 Qualified Individuals-Benefit Description; 8.252.600 Breast And Cervical Cancer-Benefit Description; 8.280.400 PACE-Recipient Policies; 8.280.600 PACE-Benefit Description; 8.281.600 Institutional Care-Benefit Description; 8.290.400 Home And Community-Based Services Waiver-Recipient Policies; 8.290.600 Home And Community-Based Services Waiver-Benefit Description; 8.292.600 Parent Caretaker-Benefit Description; 8.293.600 Pregnant Women-Benefit Description; 8.294.600 Pregnancy-Related Services-Benefit Description; 8.295.600 Children Under 19-Benefit Description; 8.296.400 Other Adults-Recipient Requirements; 8.296.600 Other Adults-Benefit Description; 8.297.400 Loss Of Parent Caretaker Medicaid Due To Spousal Support-Recipient Requirements; 8.297.600 Loss Of Parent Caretaker Medicaid Due To Spousal Support-Benefit Description; 8.298.400 Loss Of Parent Caretaker Medicaid Due To Earnings From Employment-Recipient Requirements; 8.298.600 Loss Of Parent Caretaker Medicaid Due To Earnings From Employment-Benefit Description; 8.299.400 Family Planning Services-Recipient Requirements; 8.299.600 Family Planning Services-Benefit Description; and 8.302.2 Medicaid General Provider Policies-Billing for Medicaid Services.*

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: September 25, 2018
Hearing Date: October 24, 2018

Adoption Date: January 1, 2019
Technical Citations: Centennial Care 2.0 1115 Waiver, Federal Register/Vol. 81, No. 230, 42 CFR 435.119(b)(2)

A public hearing was held on October 24, 2018, to receive public comments and testimony on this proposed rule. The Human Services Department (the Department) received oral testimony and recorded comments from two individuals. The Department received eight written comments. All oral and written comments are summarized below.

## Summary of Comments

### 1. 8.200.400 NMAC – Retroactive Medicaid

Eight commenters expressed opposition to or concern about the Department's proposed changes to limit retroactive Medicaid coverage for certain Centennial Care members as set forth at 8.200.400.14 NMAC.

These commenters conveyed concern that phasing out retroactive Medicaid would end important protections for families who rely on the safety-net. Two commenters stated that many patients do not know if they qualify for Medicaid until after they've been sick and received services, and that it may be months before families can apply for coverage. One commenter stressed the importance of retroactive coverage for individuals with disabilities. Five commenters also stated that hospitals, clinics and other providers will not be paid for care provided to these patients, and that these providers will shoulder additional uncompensated care costs. All commenters asserted that this will result in medical debt and financial burden for low-income families.

Two commenters expressed concern that the Department has not yet implemented Real-Time Eligibility (RTE) and that no timeframe has been given for RTE implementation. The commenters expressed concern that even if RTE is implemented, the need for retroactive coverage will not be eliminated because real-time determinations cannot be achieved in every case, and because retroactive coverage is needed to cover the time before the application. The commenters also stated that not every New Mexico hospital or clinic is equipped to help a person enroll in Medicaid at the time of service or before an appointment has been scheduled. The commenters expressed concern that Presumptive Eligibility/Medicaid Onsite Application Assistance (PE/MOSAA) is only available in certain clinics and requires personnel and training from the Department. One of the commenters stated that even where a provider is permitted to process PE, the patient's condition may make it impossible, thus delaying Medicaid enrollment.

Two commenters asserted that federal law does not allow states to waive retroactive Medicaid and believes that even with approval from the federal Centers for Medicare and Medicaid Services (CMS), the regulation is not allowed under federal law.

One commenter expressed support for the effort to clarify the rules for retroactive coverage by consolidating all sections in one location. The commenter also expressed gratitude to the Department that earlier proposals to eliminate retroactive coverage entirely are no longer being pursued. The commenter expressed opposition to the elimination of retroactive coverage for any

population and stated that the new policy structure is more complicated than the system that is currently in place. The commenter believes that the three-month retroactive coverage was rarely used, and thus resulted in a minimal financial burden to the state.

Five commenters expressed opposition to any imposition of premiums on the Medicaid population. Three commenters stated that non-payment of premiums resulting in an eligibility "lock-out" period would be detrimental to individuals needing services and would suffer financial consequences. One commenter stated that they do not believe the Department has sufficiently investigated or analyzed the impact of premiums on access to care for low-income patients. The commenter said that there is widespread opposition to the imposition of premiums. Two commenters referred to research and studies that they believe show that premiums will result in reduced enrollment, deter access to care and drive up health care costs. One commenter stated that the administrative costs of premiums would be greater than the amount collected from patients and expressed concern about the Department's ability to manage a premium program. Two commenters stated that they do not believe CMS has legal authority to allow states to implement premiums for populations with income below 150 percent of the federal poverty level (FPL) through a Section 1115 waiver.

**Department's Response:** The Department continues to negotiate with CMS for federal approval of these proposed changes through a Section 1115 Demonstration Waiver. Implementation will be based on federal approval and legal authority granted by CMS. Several states have already received legal 1115 waiver authority from CMS to waive certain components of the Medicaid retroactive eligibility requirements and to implement premiums for populations with income below 150 percent FPL.

The Department points out that it is not waiving retroactive Medicaid for all applicants, but is limiting the new policy to non-pregnant adults enrolled in the Centennial Care program. Further, the Department is allowing a transition period of up to one-month of retroactive coverage for affected individuals through 2019, with the elimination of retroactive coverage to begin in 2020. Pregnant women and children under age 19 will continue to receive up to three months of retroactive coverage if they qualify, in addition to individuals eligible for an Institutional Care Medicaid category and individuals covered exclusively under Medicaid fee-for-service (FFS) with full Medicaid benefits.

Approximately one percent of the Medicaid population requests retroactive Medicaid coverage today, meaning that this regulatory change will have an overall minimal impact on most Medicaid beneficiaries while helping the Department to achieve its goals of administrative simplification. The Department points out that this limitation is not being applied broadly to all, or even most, Medicaid applicants. Additionally, the Presumptive Eligibility program allows hospitals and clinics to assist Medicaid-eligible individuals to receive immediate Medicaid coverage. Medicaid-eligible individuals accessing services in these settings should not be incurring bills that require the Department to pay retroactively, but rather, should be determined presumptively eligible for Medicaid and obtain immediate coverage. The goal is to obtain and maintain Medicaid coverage so that retroactive coverage is not necessary. The Department plans to work closely with hospitals and clinics during the next year and provide additional training on

the presumptive eligibility process so that Medicaid-eligible individuals are granted coverage as soon as possible upon receiving covered services.

Regarding premiums, the Department will introduce modest premiums in July 2019 among certain adults with income above 100 percent FPL to enhance the ability of beneficiaries to become more active, responsible and involved participants in their own health care. After consultation with the public and Centennial Care 2.0 stakeholder groups, the Department's proposed premium structure, as articulated in the proposed waiver under consideration by CMS, reflects a reasonable compromise between the complete removal of premiums as requested by the commenters and the higher premium amounts that were originally proposed by the Department.

However, it must be noted that the current rule only addresses the impact of premiums on retroactive coverage and does not describe the premium program in detail. Details concerning the premium program will be part of future rulemaking that will go through the full promulgation process, inclusive of further public comment. The commenters' statements express broad and general opposition to premiums, but do not directly address the regulatory language proposed by the Department.

The Department has finalized the rule as proposed, with some revisions to the final regulatory language made for clarity. Section 8.200.400.14(D) has been updated to remove the word "mandatorily" since Native Americans can voluntarily enroll into Centennial Care and, if enrolled, are limited to one month of retroactive Medicaid. This section has also been updated to remove "as described in Subsection E of 8.200.400.14 NMAC" because FFS individuals described in Subsection F are limited to one month of retroactive Medicaid if enrolled in managed care for the month prior to the application month. The subsection reference is being replaced with "for the application month or month prior."

The final rule for Subsection E has also been updated to add "one of" and "for these categories". The wording changes are necessary to make it clear that the one month of retroactive Medicaid for Centennial Care members is limited to these specific categories. Also, "or month prior" was added because there may be individuals who are denied Medicaid for the application month but are approved and in Centennial Care the month prior, so the one-month limitation applies. The "or month prior" language was also added to Subsection F since FFS individuals are limited to one month of retroactive Medicaid if enrolled in Centennial Care for either the application month or month prior.

**2. 8.290.600 NMAC – Home and Community-Based Services Waiver – Benefit Description**

Two commenters expressed support for the proposal to allow an ongoing Nursing Facility Level of Care (NFLOC) to certain individuals covered under Centennial Care. Both commenters stated that they were of the understanding that the ongoing NFLOC would be available to individuals residing in a facility or institution, as well as to individuals receiving the Community Benefit, and were concerned that this was not part of the Department's rule proposal. One commenter stated that they were not aware that this distinction had been disclosed at any time during the

process for developing the Centennial Care 2.0 waiver. Both commenters urged the Department to make the ongoing NFLOC available to persons receiving Medicaid institutional care as well as to those served in the community. One commenter urged the Department to consider offering the same benefit to Community Benefit members during their annual Comprehensive Needs Assessment (CNA). The commenter stated that Community Benefit participants with no possibility of improvement should not have to face annual reductions in their services because of the CNA.

One commenter expressed concern that an ongoing NFLOC would not be permitted unless the individual has had a NFLOC determination for the past three years. The commenter believes that there are some conditions (i.e., quadriplegia) for which there is no reason to delay the ongoing NFLOC for three years since it is clear from the condition that it will not improve.

Both commenters expressed concern that they were unable to locate the document containing the complete criteria for an ongoing NFLOC, as referenced in the proposed rule, and inquired about whether this information had been issued for public comment. One commenter stated that the ongoing NFLOC criteria should be set forth in the regulations themselves and not in a side document that is not subject to the same requirements for public notice and promulgation as rules.

Regarding 8.290.600.11 NMAC, Subsection A, one commenter stated that it was unclear why the Department had rewritten this section in its entirety. The commenter further stated that they believed the Department was proposing to delete the requirement that services must start within 90 days of an eligibility determination. The commenter opposes this change and urged that a deadline be retained. The commenter also stated that they were unable to determine whether HSD is proposing that general Medicaid benefits start immediately upon an eligibility determination – that is, while waiting for a service plan for home and community-based services – or that no Medicaid benefits of any kind would be available until the service plan is in place. The commenter stated that eligibility for general Medicaid benefits should begin immediately once it is determined that the individual meets the eligibility criteria. The commenter urged the Department to redraft any final provision for clarity.

**Department's Response:** The Department believes it has always been clear that the ongoing NFLOC will only be available to Community Benefit members and not to Institutional Care beneficiaries. The Department included the ongoing NFLOC process for Community Benefit members only in its 1115 waiver renewal application with the Centers for Medicare and Medicaid Services (CMS). Because nursing facilities are reimbursed based on a member's low or high NFLOC status, an ongoing NFLOC would not be appropriate or applicable for individuals residing in an institution. The ongoing NFLOC criteria was posted for public comment in Section 7 – Community Benefits of the MCO Policy Manual, on September 7, 2018 and is posted on the Department's website. The Department has finalized this part of the rule as proposed.

Regarding 8.290.600.11 Subsection A, covering "Initial Benefits", the Department has added language to clarify that eligibility for general Medicaid benefits such as acute and ancillary services begins on the first day of the first month of approved Medicaid eligibility. Home and

community-based waiver services are available once the Individualized Service Plan (ISP) or Comprehensive Care Plan (CCP) is approved and implemented. The Department has reinstated language in the final rule requiring that waiver services must be provided within 90 calendar days of the approval.

3. **8.297.400 NMAC – Loss of Parent Caretaker Medicaid Due to Spousal Support – Recipient Requirements**

   **8.297.600 NMAC – Loss of Parent Caretaker Medicaid Due to Spousal Support – Benefit Description**

   **8.298.400 NMAC – Loss of Parent Caretaker Medicaid Due to Earnings from Employment – Recipient Requirements**

   **8.298.600 NMAC – Loss of Parent Caretaker Medicaid Due to Earnings from Employment – Benefit Description**

One commenter stated that they did not see the purpose or benefit of proposed changes to the Transitional Medical Assistance (TMA) categories. The commenter asserted that additional bureaucratic burdens do not improve health outcomes.

**Department's Response:** Regarding changes to TMA, federal guidance makes it clear that TMA is the Medicaid coverage of last resort for states that offer eligibility to the Other Adult (Medicaid Expansion) group. In response to this federal guidance, the eligibility rules were updated to establish TMA periods after loss of Parent/Caretaker eligibility. The TMA periods allow individuals to be considered for the Other Adult group first and only for TMA if no longer eligible for other full Medicaid coverage for the remainder of the TMA period. The Department has finalized the rule as proposed.

4. **8.299.400 NMAC – Medicaid Family Planning Services – Recipient Requirements**
   **8.299.600 NMAC – Medicaid Family Planning Services – Benefit Description**

Three commenters expressed opposition to or concern about the Department's proposed changes to limit Medicaid Family Planning eligibility requirements at 8.299.400.9 NMAC. One of these commenters also expressed concern about the Department's proposal to stop continuous eligibility for Medicaid Family Planning at 8.299.600.11 NMAC.

Two commenters expressed concern that the Department will no longer allow Family Planning coverage for individuals who have another source of health insurance, with the exception of Medicare. The commenters both stated that family planning and related services are not covered by all health insurance plans. One of the commenters urged the Department to make an exception whenever the individual's other health insurance does not offer this coverage.

Both commenters also disagreed with the age limit imposed by HSD, stating that covered services are needed beyond age 50 for men and women. One commenter recognized the concerns about administrative burden associated with the large number of individuals covered

under Medicaid Family Planning, but stated that the Department should address these concerns through improved communication rather than age limits.

One commenter expressed concern about removing continuous eligibility for individuals covered under Medicaid Family Planning, to the extent that this is not mandated by federal law or the Medicaid State Plan. The commenter expressed appreciation for HSD's proposed changes to provide 60-day postpartum Long-Acting Reversible Contraceptives (LARC).

**Department's Response:** Current policy allows Medicaid Family Planning coverage regardless of age or gender. The result is that many individuals seeking full coverage and who have no need for family planning services get placed on the Family Planning category as the Medicaid coverage of last resort. The new structure of the Medicaid Family Planning program will ensure that it continues to be provided to individuals most likely to need and utilize family planning services. Individuals who have an alternate source of full benefit health insurance will be excluded from the Medicaid Family Planning program because such insurance plans are generally required to cover family planning methods and counseling without co-payments, with few exceptions. Individuals who only have partial coverage (such as a vision or dental rider) will continue to qualify for Medicaid Family Planning if they also meet the program age and income requirements.

Regarding the Department's proposed rule to remove continuous eligibility for Medicaid Family Planning, this change is being made to align with federal rules, which do not allow continuous eligibility for this Medicaid category. Individuals covered under Family Planning will continue to be approved for 12-month certification periods, but reported changes may result in a case closure if the change would otherwise disqualify the individual from ongoing coverage.

The Department has finalized these rules as proposed.

### 5. 8.302.2 – Medicaid General Provider Policies – Billing for Medicaid Services

One commenter indicated support for the elimination of any and all co-payments and referred to research that the commenter believes shows that co-payments do not work, are cost-ineffective, and reduce positive health outcomes. Two commenters stated that it is not clear how to interpret the Department's proposed changes to 8.302.2 NMAC since the Department has declared its intention to promulgate detailed co-payment regulations at a later date.

Another commenter expressed general disagreement with any implementation of co-payments, even in nominal amounts.

**Department's Response:** As stated in the Register, the Department is sunsetting existing co-payments for the Children's Health Insurance Program (CHIP) and Working Disabled Individuals (WDI) program effective January 1, 2019. Details regarding co-payments to be implemented under Centennial Care 2.0 will be forthcoming in future rulemaking.

The Department has finalized the rule as proposed.

## 6. General Comments Received

One commenter pointed out that the Department proposes to make the revised regulations effective on January 1, 2019 (the date that Centennial Care begins), or upon federal approval by CMS. The commenter presumes that the intent is to make the changes effective on the later of those two dates to account for the possibility that CMS may not approve the Centennial Care waiver by January 1, 2019. The commenter further stated that if CMS approval is received before that date, as expected, the changes are assumed to not go into effect until the waiver renewal period begins. The commenter requested that the language of these provisions throughout the regulations be clarified.

One commenter extended gratitude to the Department for removing the mission statement, which the commenter believes is offensive. The commenter stated that they would support an effort for a global change to remove the mission statement from all NMAC sections where it remains.

Two commenters expressed concern that they were unable to review the specific language of the regulations due to a posting error by the Department. One commenter stated that the Department seemed to believe it did not need to publish all of its proposed changes where the public notice directed readers to find them, as long as they were posted somewhere. Both commenters suggested that the Department should republish the rules and allow for a new public comment period.

The Department received one comment urging the withdrawal of proposed changes and a focus on new waiver policies that will improve access to care, such as: improvements to care coordination, expanding Centennial Care home visiting, implementing a seamless suspension process for individuals being released from incarceration, and taking advantage of opportunities to leverage federal funding to address other social determinants, such as supportive housing and primary care workforce development.

Another commenter asserted that there are other ways to increase funding for the public health care system without jeopardizing the economic status of low-income populations. For example, the commenter suggested getting procurement contracts with life insurance companies that have long-term care programs. The commenter believes that by adopting such a proposal, the overall cost per person could decrease because the long-term care insurance would cover the highest risk patients with chronic and severe conditions. The commenter suggested that by merging risks, the total pool of members divides the cost more efficiently. The commenter also suggested opening urgent care at public hospitals on weekends to avoid excessive costs in emergency services during those days.

**Department's Response:** Regarding the implementation date of changes, the Department agrees to add clarifying language and has updated each rule accordingly to explain that implementation will occur on the later of the two dates (either on January 1, 2019, or upon CMS approval of the Centennial Care 2.0 waiver, whichever is later).

Regarding publication of the proposed rules and the availability of these documents for public review, all materials were continuously posted on the HSD website at one of the locations that

was published in the Register. HSD acknowledges a posting error at one of the alternative websites for viewing the proposed documents. Two websites were offered for viewing all materials; the error was only made at one of the posting locations. Both websites were included in both the public notice and the Register. Since the posting error was brought to the Department's attention, the Department issued a notice to interested parties on October 25, 2018, extending the public comment period to Thursday, November 1, 2018, as a courtesy to the public. Since the documents were always available at one of the published locations, repromulgating the proposed rules or restarting the public comment period is not necessary.

The Department appreciates suggestions by the commenters regarding how to achieve cost-savings, and is open to recommendations that may improve the health care system.

## VI. RULES

These amendments will be contained in 8.200.400 General Recipient Rules-General Medicaid Eligibility, 8.201.600 Medicaid Extension-Benefit Determination, 8.215.600 SSI Methodology-Benefit Description, 8.231.600 Infants Of Mothers Who Are Medicaid Eligible-Benefit Description, 8.242.600 Qualified Disabled Individuals Whose Income Exceeds QMB And SLIMB-Benefit Description, 8.243.400 Working Disabled Individuals-Recipient Policies, 8.243.600 Working Disabled Individuals-Benefit Description, 8.245.600 Specified Low Income Medicare Beneficiaries-Benefit Description, 8.249.600 Refugee Medical Assistance-Benefit Description, 8.250.600 Qualified Individuals-Benefit Description, 8.252.600 Breast And Cervical Cancer-Benefit Description, 8.280.400 PACE-Recipient Policies, 8.280.600 PACE-benefit Description, 8.281.600 Institutional Care-Benefit Description, 8.290.400 Home And Community-Based Services Waiver-Recipient Policies, 8.290.600 Home And Community-Based Services Waiver-Benefit Description, 8.292.600 Parent Caretaker-Benefit Description, 8.293.600 Pregnant Women-Benefit Description, 8.294.600 Pregnancy-Related Services-Benefit Description, 8.295.600 Children Under 19-Benefit Description, 8.296.400 Other Adults-Recipient Requirements, 8.296.600 Other Adults-Benefit Description, 8.297.400 Loss Of Parent Caretaker Medicaid Due To Spousal Support-Recipient Requirements, 8.297.600 Loss Of Parent Caretaker Medicaid Due To Spousal Support-Benefit Description, 8.298.400 Loss Of Parent Caretaker Medicaid Due To Earnings From Employment-Recipient Requirements, 8.298.600 Loss Of Parent Caretaker Medicaid Due To Earnings From Employment-Benefit Description, 8.299.400 Family Planning Services-Recipient Requirements, 8.299.600 Family Planning Services-Benefit Description, and 8.302.2 Medicaid General Provider Policies-Billing for Medicaid Services.

The final register and rule languages 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 MAD in Santa Fe at (505) 827-6252.

## VII. EFFECTIVE DATE

These rules have an effective date of January 1, 2019.

## VIII. PUBLICATION

Publication of these rules approved by:

BRENT EARNEST, SECRETARY
HUMAN SERVICES DEPARTMENT