

September 27, 2018

RE: Tribal Notification to Request Advice and Comments Letter 18-11

Dear Tribal Leadership, Indian Health Service, Tribal Health Providers, and Other Interested Parties:

Seeking advice and comments from New Mexico's Indian Nations, Tribes, Pueblos and their health care providers is an important component of the government-to-government relationship with the State of New Mexico. In accordance with the New Mexico Human Services Department's (HSD's) Tribal Notification to Request Advice and Comments process, this letter is to inform you that HSD, through the Medical Assistance Division (MAD), is accepting written comments until **5:00pm Mountain Daylight Time (MDT) on October 29, 2018**, regarding proposed amendments to the following New Mexico Administrative Code (NMAC) rules in order to implement certain changes as part of the Department's Centennial Care 1115 Demonstration Waiver effective January 1, 2019, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS):

- *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*
- 8.302.2 *Medicaid General Provider Policies – Billing for Medicaid Services*

As part of the rule promulgation, the following NMAC sections are being repealed and replaced to comply with formatting requirements: 8.201.600, 8.215.600, 8.242.600, 8.243.400, 8.243.600, 8.245.600, 8.249.600, 8.250.600, 8.280.400, and 8.280.600 NMAC.

## **A. Proposed Revisions to Retroactive Medicaid Policy**

### **8.200.400 NMAC**

#### **Section 14**

The Department proposes language describing the policy for retroactive Medicaid in one location. Policies for specific categories of eligibility will reference Section 14 regarding retroactive Medicaid. The Department proposes to revise the policy for retroactive Medicaid to limit Centennial Care managed care members to one month of retroactive Medicaid prior to the application month. This is a change from the three months of retroactive Medicaid allowed under current rule.

Under the proposed rule, the following Centennial Care managed care members are limited to one month of retroactive Medicaid: Other Adults, Parent/Caretaker, Supplemental Security Income (SSI), SSI extensions, Working Disabled Individuals (WDI), and Breast and Cervical Cancer (BCC). Medicaid fee-for-service (FFS) individuals in these categories who are not enrolled in managed care during the month of application are allowed up to three months of retroactive Medicaid prior to the application month.

Beginning July 1, 2019, individuals covered under the Other Adults category who have household income above 100% of the federal poverty level (FPL) will have a premium requirement. The proposed rule explains that individuals covered under the Other Adults category who have a premium requirement will not be eligible for retroactive Medicaid. Premium requirements cited in this register will be addressed separately in a different proposed register.

The following categories of Medicaid are allowed up to three months of retroactive Medicaid regardless of Centennial Care managed care enrollment: Children under Age 19 (including Newborn and the Children’s Health Insurance Program (CHIP)), Pregnant Women, Pregnancy-

Related Services, Family Planning, Specified Low-Income Medicare Beneficiary (SLIMB), Medicare Savings Program Qualifying Individuals (QI1), Qualified Disabled Individuals, Refugee, Children, Youth and Families Department (CYFD) Medicaid categories, and Institutional Care Medicaid, excluding the Program of All-Inclusive Care for the Elderly (PACE).

The following categories will not be eligible for retroactive Medicaid, in accordance with current policy: Emergency Medical Services for Aliens (EMSA), Home and Community-Based Services Waivers, PACE, Qualified Medicare Beneficiary (QMB), and Transitional Medical Assistance (TMA). EMSA will continue to provide coverage for services that may have been provided prior to the application month, but is not considered retroactive Medicaid.

For newborns, the retroactive Medicaid policy that was at 8.231.600.12 NMAC remains the same but has been moved to 8.200.410.14 NMAC.

### **8.201.600 NMAC**

#### **Section 13**

The Department proposes to amend the SSI extension categories of Medicaid to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.215.600 NMAC**

#### **Section 10**

The Department proposes to amend the SSI categories of Medicaid to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.231.600 NMAC**

#### **Section 12**

The Department proposes to amend the newborn category section to refer to 8.200.410.14 NMAC.

### **8.242.600 NMAC**

#### **Section 13**

The Department proposes to amend the Qualified Disabled Working Individuals category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.243.600 NMAC**

#### **Section 13**

The Department proposes to amend the WDI category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.245.600 NMAC**

#### **Section 13**

The Department proposes to amend the SLIMB category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.249.600 NMAC**

#### **Section 13**

The Department proposes to amend the Refugee category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.250.600 NMAC**

#### **Section 13**

The Department proposes to amend the QII category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.252.600 NMAC**

#### **Section 13**

The Department proposes to amend the BCC category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.292.600 NMAC**

#### **Section 10**

The Department proposes to amend the Parent Caretaker to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

### **8.293.600 NMAC**

#### **Section 10**

The Department proposes to amend the Pregnant Women category to remove the retroactive language and refer to 8.200.410.14 NMAC.

### **8.294.600 NMAC**

#### **Section 10**

The Department proposes to amend the Pregnancy-Related Services category to remove the retroactive language and refer to 8.200.410.14 NMAC.

### **8.295.600 NMAC**

#### **Section 10**

The Department proposes to amend the Children Under Age 19 to remove the retroactive language and refer to 8.200.410.14 NMAC.

## **8.296.600 NMAC**

### **Section 10**

The Department proposes to amend the Other Adults category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

## **8.299.600 NMAC**

### **Section 10**

The Department proposes to amend the Family Planning category to delete the three-month retroactive language and refer to 8.200.410.14 NMAC.

## **B. Proposed Revisions to Medicaid Family Planning Policy**

## **8.299.400 NMAC**

### **Section 9**

The Department proposes to amend rules for the Medicaid Family Planning category to state that an individual must be under the age of 51 and not have other health insurance to be eligible. Individuals who are under the age of 65 who have only Medicare and no other health insurance are also eligible for Medicaid Family Planning.

## **8.299.600 NMAC**

### **Section 11**

The Department proposes to amend rules for the Medicaid Family Planning category to remove the continuous eligibility language and refer to change reporting policy. The Code of Federal Regulations (CFR) and Medicaid State Plan do not permit continuous eligibility for Medicaid Family Planning, so this change is being proposed to comply with federal regulations.

## **C. Proposed Ongoing Nursing Facility Level of Care (NF LOC) for Certain Community Benefit Participants in Centennial Care**

Individuals covered under the Centennial Care managed care program may receive the Community Benefit when they meet NF LOC. Community Benefit requirements are located in program policy at 8.308.12 NMAC. Through the Centennial Care 1115 Demonstration Waiver renewal effective January 1, 2019, an ongoing NF LOC is allowed for managed care Community Benefit participants who meet certain criteria. The Department proposes to update 8.290.600 NMAC to allow for an ongoing NF LOC for these individuals.

NF LOC determinations are made by the utilization review contractor or a member's selected or assigned managed care organization (MCO), as applicable to the Centennial Care Community Benefit program. LOC reviews are required to be completed at least annually except for certain Community Benefit members whose chronic condition is not expected to improve. These individuals may be eligible for an ongoing NF LOC. To qualify for an ongoing NF LOC, the Community Benefit member must have met a NF LOC for the previous three years. The ongoing NF LOC status must be reviewed and approved annually by the MCO's medical director and must be supported in documentation by the

member's physician. The complete criteria for an ongoing NF LOC can be found in the New Mexico Medicaid NF LOC criteria and instructions document.

Meeting NF LOC is a requirement for Institutional Care (IC) and some Home and Community-Based Services (HCBS) categories. IC Medicaid clients are not eligible for an ongoing NF LOC because these individuals are not eligible for the Community Benefit. PACE clients are not eligible for an ongoing NF LOC because their services are provided under fee-for-service and not managed care, so the Community Benefit is not available to these individuals.

#### **8.290.600 NMAC**

##### **Section 12**

The Department proposes to amend language for the HCBS waiver categories to add language that LOC reviews are required at least annually, except for certain Community Benefit members whose chronic conditions are not expected to improve. These individuals may be eligible for an ongoing NF LOC. Outdated language was deleted and additional language was inserted to clarify that LOC determinations are made by the utilization review contractor or a member's selected or assigned MCO.

#### **D. Proposed Elimination of Existing Co-Payments for CHIP and WDI**

As part of the Centennial Care 1115 Demonstration Waiver, the Department proposes to sunset existing co-payments specific to CHIP and WDI clients. New co-payment rules are proposed at 8.302.2 and 8.308.14 NMAC.

#### **8.243.400 NMAC**

##### **Section 18**

The Department proposes to eliminate language referencing specific co-payments for WDI individuals effective January 1, 2019.

#### **8.243.600 NMAC**

##### **Section 12**

The Department proposes to eliminate references to co-payments in this Section.

#### **8.295.600 NMAC**

##### **Section 9**

The Department proposes to eliminate language referencing specific co-payments for CHIP individuals effective January 1, 2019. Language was also updated to clarify that eligibility extends through age 18.

## **E. Proposed Revisions to Other Adults Category**

### **8.296.400 NMAC**

#### **Section 9**

The Department proposed additional language to exclude individuals who are pregnant per 42 CFR 435.119(b)(2). New language was added to explain that individuals with household income above 100% FPL will be subject to a premium and are enrolled into the Other Adults category prospectively starting July 1, 2019. Native Americans are exempt from premium requirements. Premium requirements cited in this register will be addressed separately in a different proposed register.

## **F. Other Proposed Revisions to Medicaid Eligibility Rules**

### **8.200.400.10 NMAC**

#### **Section 10**

The Department proposes to remove outdated language regarding waiver programs. The Emergency Medical Services for Aliens (EMSA) section was updated to replace the outdated term “alien” with “non-citizen” and to remove the statement that EMSA individuals do not receive the full Medicaid benefit package, since the service limitation is already cited in the next sentence in the rules.

### **8.290.400 NMAC**

#### **Section 7**

The Department proposes to add definitions for Comprehensive Care Plan (CCP), Primary Freedom of Choice (PFOC), and Medically Fragile; and to update the definition of Waiver. Acronyms for the Disability Determination Unit (DDU) and HCBS were also added.

#### **Section 9**

The Department proposes to add language to clarify that the LOC requirements for Medically Fragile and Developmentally Disabled categories are an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) LOC. Language was added regarding the Community Benefit for elderly, blind, and disabled Medicaid categories who meet NF LOC.

#### **Section 10**

Outdated language was deleted regarding the Coordination of Long-Term Services (CoLTS) waiver, which has not existed for several years. Language was added to clarify that a disability or blindness determination can be determined by the Social Security Administration (SSA). Section 10 was further amended to expand who is characterized as a Medically Fragile individual.

Language was also amended to clarify that the AIDS and AIDS-related condition waiver ceased covering new individuals effective January 1, 2014, since the waiver was sunset and not renewed. Individuals already on the AIDS and AIDS-related condition waiver are grandfathered in and remain covered as long as eligibility requirements are met. Language was added to clarify that the Brain Injury (BI) category also stopped covering new individuals

effective January 1, 2014. Those already on the BI waiver were grandfathered in and remain covered as long as eligibility requirements are met.

### **Section 11**

The Department proposes to delete language requiring the Individual Service Plan (ISP) to be in effect for 30 days for an application to be approved. New proposed language regarding approval of waiver applications is contained at 8.290.600 NMAC and included in this register.

Proposed language was also added regarding the requirement to meet all non-financial eligibility criteria, which includes any mandatory income or resources deemed to a minor child. This Section was also amended with respect to enumeration to reference 8.200.410.10 NMAC. The reference to citizenship was updated to be more precise. Outdated acronyms were updated.

This Section was also amended to increase the number of consecutive days in which a waiver recipient can be out of waiver services before eligibility is closed. The increase from 60 consecutive days to 90 consecutive days will allow for equity among all waiver recipients, specifically for recipients receiving services under New Mexico's 1115 Centennial Care Medicaid Demonstration Waiver.

### **Section 12**

The Department proposes to update acronyms that are outdated. Language is also proposed to clarify that LOC reviews are also completed by the MCO.

## **8.290.600 NMAC**

### **Section 10**

The Department amended this Section to add acronyms for ISD and the DDU.

### **Section 11**

The Department proposes to delete outdated language requiring the ISP to be in effect 30 days for an application to be approved. New language was also added to clarify when Medicaid and Waiver services eligibility begins.

### **Section 13**

The Department proposes to add language to clarify that since eligibility for waiver programs is prospective, retroactive coverage is not available.

### **Section 14**

This section was amended to correct a typo. Language is also proposed in this Section to allow for 90 consecutive days as opposed to the current 60 days for non-provision of waiver services before a waiver case is closed.

## **8.280.400 NMAC**

### **Section 11**

The Department proposes to add a new sentence to clarify that interviews are required for PACE individuals at initial application in accordance with Institutional Care rules found at 8.281.400 NMAC. Outdated language was also updated.



**Section 13**

This section was updated to delete outdated language and add the applicable change reporting reference.

**8.280.600 NMAC**

**Section 10**

This section was updated to remove outdated language and reference the HSD 100 application.

**Section 12**

This section was amended to delete outdated language and clarify that LOC determinations for PACE are made by the utilization review contractor.

**Section 14**

This section was amended to add that an exception to closure of PACE for services not being provided can be prior authorized by MAD. Outdated language was updated.

**8.281.600 NMAC**

**Section 10**

This section was updated to remove outdated language and reference the HSD 100 application.

**Section 12**

This section was amended to delete outdated language and clarify that LOC determinations are made by the utilization review contractor or a member's selected or assigned MCO.

**8.293.600.10 and 8.294.600.10 NMAC**

**Section 10**

The Department proposes amendments in both the Pregnant Women and Pregnancy-Related services categories to add language from 42 CFR 435.4 that allows for a 60-day postpartum period of Medicaid coverage. Current policy allows for a postpartum coverage period of two months following the birth month. This change is being made to comply with the CFR language.

**8.297.400 NMAC**

**Section 9**

The Department proposes to amend language regarding Transitional Medical Assistance (TMA) due to Loss of Parent Caretaker Medicaid due to Spousal Support. TMA is the full Medicaid coverage of last resort. A parent or caretaker is evaluated for other full Medicaid coverage, including Other Adults Medicaid, before being placed on the TMA category of eligibility per Federal Register Vol. 81, No. 230. A parent or caretaker losing full Medicaid coverage during any month(s) of his or her four-month TMA period is automatically placed on the TMA category. The Medicaid eligibility certification period of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s). This section was further amended to state that new TMA periods beginning on or after July 1, 2019,

are subject to a premium for eligibility months during which an individual is on the TMA category 027. Native Americans are exempt from the premium requirement. Premium requirements cited in this register will be addressed separately in a different proposed register.

### **8.297.600 NMAC**

#### **Section 11**

The Department proposes to amend language regarding TMA due to Loss of Parent Caretaker Medicaid due to Spousal Support. This section was amended to delete language stating that a new application must be submitted after the four-month TMA period expires. A redetermination of eligibility is conducted in accordance with 8.291.410.19 NMAC, which allows for an administrative renewal, pre-populated renewal form, and a 90-day reconsideration period.

### **8.298.400 NMAC**

#### **Section 9**

The Department proposes to amend language regarding TMA due to Loss of Parent Caretaker Medicaid due to Earnings from Employment. TMA is the full Medicaid coverage of last resort. A parent or caretaker is evaluated for other full Medicaid coverage, including Other Adults Medicaid, before being placed on the TMA category of eligibility per Federal Register Vol. 81, No. 230. A parent or caretaker losing full Medicaid coverage during any month(s) of his or her 12-month TMA period is automatically placed on the TMA category. The Medicaid eligibility certification period of dependent children living in the home is extended to at least match the TMA period of parent(s) and guardian(s). This section was further amended to state that new TMA periods beginning on or after July 1, 2019 are subject to a premium for eligibility months an individual is on the TMA category 028. Native Americans are exempt from the premium requirement. Premium requirements cited in this register will be addressed separately in a different proposed register.

### **8.298.600 NMAC**

#### **Section 11**

The Department proposes to amend language regarding TMA due to Loss of Parent Caretaker Medicaid due to Earnings from Employment. This section was amended to delete language stating that a new application must be submitted after the 12-month TMA period expires. A redetermination of eligibility is conducted in accordance with 8.291.410.19 NMAC, which allows for an administrative renewal, pre-populated renewal form, and a 90-day reconsideration period.

### **8.302.2 NMAC**

#### **Section 10**

The Department proposes to remove detailed language in this section regarding co-payment requirements. The Department clarifies that co-payment requirements are required under the Medicaid managed care program only, and proposes removing details from this section and instead citing to the managed care section of rule at 8.308.14 NMAC.

The Department also proposes to sunset existing co-payments for the CHIP and WDI programs effective January 1, 2019. Language regarding CHIP and WDI co-payments has been removed.

The Department intends to propose additional revisions of 8.308.14 NMAC that will specify new co-payment requirements as part of the 1115 Demonstration Waiver renewal for Centennial Care with a proposed effective date of March 1, 2019, contingent upon approval by CMS. Proposed revised language for 8.308.14 NMAC will be promulgated by the Department at a later date.

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: Proposed as January 1, 2019

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

### **Estimated Total Financial Impact**

Implementation of these rule changes will result in the following estimated cost savings to the Medicaid program for calendar year 2019:

1. Limit Retroactive Medicaid – Estimated savings is a total of \$10,993,000 (\$1,810,000 in state general funds).
2. New eligibility requirements for the Medicaid Family Planning program – Estimated savings is a total of \$2,780 (\$833 in state general funds).

Other proposed changes do not have substantive savings to the Medicaid program.

### **Tribal Impact**

Limiting Retroactive Medicaid for most Centennial Care non-pregnant adults to one month prior to the application month will have a tribal impact. Native Americans who are enrolled in Centennial Care during the application month will be limited to one month of Retroactive Medicaid. Native Americans who do not choose a Centennial Care MCO on their application may receive up to three months of Retroactive Medicaid. Native Americans may continue to opt-in and opt-out of Centennial Care at their choice.

The following categories of Medicaid will be allowed up to three months of retroactive Medicaid, regardless of Centennial Care enrollment: Pregnant Women, Pregnancy-Related Services, Family Planning, SLIMB and Q11, Qualified Disabled Individuals, Refugee, CYFD Medicaid categories, and Institutional Care Medicaid (excluding PACE). Pregnant women and children under age 19 on any Medicaid category during the application month are allowed up to three months of retroactive Medicaid.

Retroactive Medicaid will not be allowed for the following categories, which is a continuation of current policy: Emergency Medical Services for Aliens (EMSA), Home and Community-Based

Services Waivers, PACE, QMB, and TMA. EMSA will continue to provide coverage for services that may have been provided prior to the application month, but is not considered Retroactive Medicaid. For newborns, the retroactive policy that was at 8.231.600.12 NMAC remains the same but has been moved to 8.200.410.14 NMAC.

The proposed changes to Family Planning Medicaid will also have a tribal impact. Medicaid Family Planning is currently provided to individuals without an age limit. The proposed rule will limit the Family Planning program to individuals who are under the age of 51, and will not provide coverage to individuals of any age who have other health insurance. An exception will be allowed for individuals who are under the age of 65 who have only Medicare, and such individuals may continue to receive Family Planning. HSD is also revising the rules to clarify that 12-month continuous eligibility is not allowed for Family Planning. As a result of the proposed rule, fewer Native Americans will be eligible for Family Planning Medicaid.

The proposed rules revise Home and Community-Based Services waiver eligibility policy to allow for an ongoing NF LOC for Community Benefit members under Centennial Care who meet certain criteria. This change will have a positive impact to Native Americans because these individuals will no longer have an annual LOC assessment. An ongoing NF LOC is available for individuals on a full Medicaid category, including Other Adults receiving the Community Benefit, who meet the criteria stated in the proposed rule.

New language was added to the proposed rules that certain individuals with income above 100 percent of the federal poverty level (FPL) will be subject to premiums. There is no impact to Native Americans, since Native Americans will be exempt from the premium requirement.

The proposed rules clarify the Medicaid postpartum period for pregnant women to align with federal regulations, which may have some tribal impact. Current policy allows for a two-month postpartum period after the birth month. The new policy terminates Medicaid eligibility for pregnancy categories at the end of the month in which the 60-day postpartum period has ended. This change is being made to comply with federal policy, which has a 60-day postpartum limitation.

### **Tribal Advice and Comments**

Tribes and tribal health care providers may view the proposed rules on the HSD webpage at: <http://www.hsd.state.nm.us/providers/written-tribal-consultations.aspx> *Notification Letter 18-11.*

A written copy of these documents may be requested by contacting the HSD Medical Assistance Division (HSD/MAD) in Santa Fe at (505) 827-6252.

### **Important Dates**

**A public hearing on these rules is scheduled to be held in the Rio Grande Conference room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM on October 24, 2018 from 9 a.m. to 12 p.m. MDT.**

**Written advice and comments must be received no later than 5:00pm Mountain Daylight Time (MDT) on October 29, 2018.** Please send your advice, comments or questions to the MAD Native American Liaison, Theresa Belanger, at (505) 827-3122 or by email to [theresa.belanger@state.nm.us](mailto:theresa.belanger@state.nm.us).

All comments and responses will be compiled and made available after November 8, 2018.

Sincerely,

Handwritten signature in black ink, appearing to read "KAM for NSL".

Nancy Smith-Leslie  
Director

cc: Kari Armijo, HSD/MAD Deputy Director  
Theresa Belanger, Native American Liaison, HSD/MAD  
HSD/MAD Centennial Care Bureau  
HSD/MAD Program Policy Bureau