NOTICE OF RULEMAKING

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to amend the following New Mexico Administrative Code (NMAC) 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; 8.302.2 - Medicaid General Provider Policies-Billing for Medicaid Services; and 8.308.14 - Managed Care Programs-Co-Payments.

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).

The Department is proposing to revise these rules to align with the Department's Centennial Care 1115 Demonstration Waiver renewal effective January 1, 2019, or as otherwise approved by the Centers for Medicare and Medicaid Services (CMS).

As part of the rule promulgation, the following NMAC rules 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 QI1 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.

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.

8.308.14 NMAC

New wording in the proposed rule at 8.308.14 NMAC specifies new co-payment requirements as part of the 1115 Demonstration Waiver renewal for Centennial Care. The proposed effective date of new co-payment requirements is March 1, 2019, contingent upon approval by CMS. This section of the rule specifies the amount of each co-payment; to whom the co-payment applies; the categories of eligibility and services that are exempt from co-payments; the responsibilities of Medicaid providers for charging, collecting and reporting co-payments; the responsibilities of contracted MCOs for tracking co-payments; the rights and responsibilities of MCO members; and other specific information regarding the application of co-payments.

Section 9

The Department proposes new co-payment amounts for non-emergency care furnished in the hospital Emergency Department (ED) and non-preferred prescription drugs. Both co-payments amounts are proposed to be set at $8.

The proposed rule defines the co-payment types and describes the conditions under which each type of co-payment may be charged to a member. This section further describes the members who are exempt from co-payments, including: Native American members who are active or previous users of the Indian Health Service (IHS), tribal 638 programs, or urban Indian health programs, and who are coded as Native American in the Department's eligibility and enrollment system; members who are enrolled in the 1915(c) Developmentally Disabled (DD) waiver program; members who are enrolled in an Institutional Care (IC) category of eligibility; members with verified household income of zero percent of the federal poverty level (FPL); members for whom the Department does not have income information because of a pass-through eligibility determination made by another agency; and members who are receiving hospice care.

The proposed rule further defines requirements of the MCOs regarding co-payments, including the requirement to track the accumulation of co-payments toward an aggregate limit of five percent of the member's household income, and to notify member households of both their aggregate maximum amount and their co-payment accumulations on a quarterly basis.

The proposed rule also sets forth the responsibilities of MCO contracted providers in applying and administering co-payments; and the rights and responsibilities of MCO members who are charged co-payments.

This register and the proposed rules are available on the HSD website at: http://www.hsd.state.nm.us/2017-comment-period-open.aspx and http://www.hsd.state.nm.us/LookingForInformation/registers.aspx. If you do not have internet access, a copy of the proposed register and rules may be requested by contacting MAD at (505) 827-6252.

The Department proposes to implement these rules effective January 1, 2019, or as otherwise approved by CMS. A public hearing to receive testimony on these proposed rules will be held in the Rio Grande Conference room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico on October 24, 2018 from 9 a.m. to 12 p.m., Mountain Daylight Time (MDT).

Interested parties may submit written comments directly to: Human Services Department, Office of the Secretary, ATT: 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. MDT on October 25, 2018. Written and recorded comments will be given the same consideration as oral testimony made at the public hearing. All written comments received will be posted as they are received on the HSD website at http://www.hsd.state.nm.us/2017-comment-period-open.aspx along with the applicable register and rules. The public posting will include the name and any contact information provided by the commenter.

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 ten (10) days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available by the 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.