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Sent Via Email: HCA-madrules@hca.nm.gov

Re: Proposed Amendments to Medicaid Eligibility Rules Implementing Federal H.R. 1 Changes

Dear Secretary Armijo and Director Dancis,

Thank you for the opportunity to comment on the proposed amendments implementing Medicaid changes required by H.R. 1. The proposed rules address work reporting requirements for Other Adults Medicaid, six-month renewals, limitations on retroactive coverage, updated address procedures, and quarterly screening against the Social Security Administration death master file. See Proposed NMAC 8.200.400.14, .16; 8.291.410.19, .27; 8.296.400.9-.11.

We appreciate HCA's efforts to incorporate the federal requirements into the New Mexico Administrative Code. We respectfully recommend the following revisions and implementation commitments to ensure that the proposed rules are understandable and accessible to applicants and beneficiaries and do not result in avoidable losses of coverage or interruptions in care.

I. HCA should require proactive, plain-language work reporting requirement outreach and notices.

Proposed NMAC 8.296.400.11 establishes an extensive work reporting requirement framework. The rule addresses qualifying activities, including work, community service, work-program participation, educational enrollment, combined activities, income, and seasonal-worker income. Proposed NMAC 8.296.400.10; 42 C.F.R. § 435.552. It also includes mandatory exceptions, specified excluded individual categories, short-term hardship exceptions,

verification rules, and noncompliance procedures. Proposed NMAC 8.296.400.11(G)–(L); 42 C.F.R. §§ 435.553–.558.

The proposed notice-of-noncompliance requirements are critical. HCA must notify an individual the reasons and facts why it believes there is non-compliance; how to make a satisfactory showing; identify the month or months it will assess; explain how to demonstrate "community engagement" (CE), deemed compliance, or excluded status; provide a deadline and submission options; explain consequences; provide reapplication information; and identify short-term hardship information. Proposed NMAC 8.296.400.11(L)(3); 42 C.F.R. § 435.558(c).

HCA should require equivalent, understandable information to be provided before an individual reaches the noncompliance stage. Specifically, HCA should provide a concise CE summary at enrollment, before the beneficiary's first CE assessment, and with each Other Adults renewal. The summary should explain:

- Who is subject to CE.
- The available ways to demonstrate CE.
- The difference between a specified exclusion, a mandatory exception, and a short-term hardship exception.
- How to report a change that may establish an exclusion or exception.
- The manner in which HCA will assess CE at application and renewal.
- How to provide information or seek assistance.
- The consequences of failing to respond to a CE notice.
- The availability of fair-hearing rights and the ability to reapply after a CE-related adverse action.

The federal CE outreach rule requires states to provide information about CE compliance, exceptions, exclusions, consequences of noncompliance, and the reporting of status changes. 42 C.F.R. § 435.561(c). That outreach must be provided by regular mail or a properly elected electronic format and through at least one additional modality, such as the individual's electronic account, telephone, text message, or other commonly available electronic means. 42 C.F.R. § 435.561(d). HCA should expressly commit to using these required outreach methods in forms, operational policies, and public guidance.

HCA should also ensure that all CE-related notices use plain language, are accessible to people with disabilities and people with limited English proficiency, and identify the particular information HCA needs from the individual. See 42 C.F.R. § 435.905(b); Proposed NMAC 8.291.410.19(G); Proposed NMAC 8.296.400.11(L)(3). A beneficiary should be able to tell from the notice what month is at issue, what information HCA could not verify, what can resolve the issue, how to respond, and when a response is due. Due process and federal law mandate no less.

II. HCA should establish accessible processes for work reporting responses and hardship requests.

When HCA cannot verify work reporting compliance, deemed compliance, or specified excluded status, the proposed rule requires HCA to provide a notice of noncompliance and give

the individual 30 calendar days from receipt of the notice to make a satisfactory showing. Proposed NMAC 8.296.400.11(L)(1); 42 C.F.R. § 435.558(a). The proposed rule treats the notice as received five days after its date unless the individual establishes that it was not received within that period. Proposed NMAC 8.296.400.11(L)(3)(d); 42 C.F.R. § 435.558(c)(4).

HCA should clearly state in its final rule, forms, and implementation materials that people may respond to CE requests and notices through every method available for Medicaid applications: online, by telephone, by mail, in person, and through other commonly available electronic means. Proposed NMAC 8.291.410.18(A); 42 C.F.R. § 435.907(a). The CE provisions already incorporate these modalities for other information and documentation related to work reporting requirements. Proposed NMAC 8.296.400.11(K)(1)(d), (L)(3)(a)(vi).

HCA should also provide clear confirmation that CE-related information has been received, particularly when information is submitted by telephone, online, mail, or in person. Clear confirmation can prevent an avoidable termination when an individual has timely provided information but HCA has not associated it with the correct case or CE review period.

HCA has elected to offer short-term hardship exceptions for people receiving inpatient or similarly acute services, people affected by qualifying emergencies or disasters, people in qualifying high-unemployment areas, and people who must travel outside their community for needed medical services for a serious or complex medical condition. Proposed NMAC 8.296.400.11(I)(3); 42 C.F.R. § 435.555(d). HCA will automatically apply some location-based exceptions, but individuals or persons acting on their behalf must request the exceptions related to certain acute medical services and medical travel. Proposed NMAC 8.296.400.11(I)(4), (K)(1)(l)(iii).

HCA should make request-based hardship exceptions easy to identify and use. Every CE outreach notice, renewal form, request for information, and notice of noncompliance should explain:

- The hardship exceptions that may apply.
- How to request an exception.
- The timeframe for requesting it.
- All available submission methods.
- That an individual acting on the beneficiary's behalf may request an exception or submit relevant information.
- The right to a timely written determination, including the anticipated end date of a granted exception.
- The right to appeal an adverse hardship determination.

These recommendations are consistent with the procedures HCA has proposed. Proposed NMAC 8.296.400.11(I)(2); 42 C.F.R. § 435.555(c). HCA should also publish a simple request form or screening tool for short-term hardship exceptions in paper, online, telephonic, and accessible electronic formats.

III. HCA should establish notices and procedures to properly communicate and apply exemptions from work reporting requirements for those in households receiving SNAP benefits.

Proposed NMAC 8.296.400.10(H)(7) establishes a specific exclusion to Medicaid CE requirements for any individual who is "a member of a household that receives supplemental nutrition assistance program (SNAP) benefits under 7 U.S.C. 2015 and is not exempt from a work requirement under such Act." HCA already has an obligation to provide written and verbal explanations of SNAP work requirements for all nonexempt members of a household. 7 C.F.R. § 273.7(c)(ii). HCA is already aware of individuals in households which receive SNAP and who are not exempt from SNAP work requirements. HCA should therefore take the necessary steps to program the eligibility system to automatically exclude these individuals from CE requirements for Medicaid.

HCA should offer a clear and concise explanation as to who would qualify for the exclusion from Medicaid CE requirements recorded at NMAC 8.296.400.10(H)(7) which could be included in summaries of CE requirements suggested above.

Additionally, because this exclusion may not be readily apparent to ISD employees reviewing an application, HCA should take special care to provide training materials on this topic. An individual who qualifies for this exclusion does not need to be receiving SNAP themselves, nor do they even have to be compliant with SNAP work requirements. If an individual is in a household where anyone is receiving SNAP benefits AND that individual is not exempt from a SNAP work requirement, then that individual will be excluded from Medicaid CE requirements. It is possible that an individual could be denied SNAP benefits for non-compliance with SNAP work requirements, another member of the same household could still be receiving benefits and the individual who was denied SNAP benefits would still be exempt from Medicaid CE requirements. Because of the way these work requirements interact with one another, it is very possible that applicants and HCA workers could get confused.

To ensure correct program administration, HCA should take special care to design notices, training and procedures to make sure that people who qualify for this exclusion are not unnecessarily subject to CE requirements which could lead to disenrollment.

IV. HCA should maximize *ex parte* renewals and clearly communicate the six-month renewal transition.

Proposed NMAC 8.291.410.19(A)(1) establishes six-month renewal periods for Other Adults Medicaid for renewals initiated on or after January 1, 2027. Native Americans in the Other Adults category continue to receive 12-month renewal periods. Proposed NMAC 8.291.410.19(A)(1); see also § 1902(e)(14)(L) of the Social Security Act.

The proposed rule retains the *ex parte* renewal process. HCA must make a redetermination without requesting information from the beneficiary when it can do so using reliable information in the individual's account or other current information available to HCA. Proposed NMAC 8.291.410.19(A)(2); 42 C.F.R. § 435.916(a)(2). When HCA cannot complete an *ex parte* renewal, it must provide a pre-populated renewal form, allow at least 30 days to respond, accept responses through all application modalities, verify information returned by the

beneficiary, and provide notice of the renewal decision. Proposed NMAC 8.291.410.19(A)(3); 42 C.F.R. §§ 435.907(a), 435.916(a)(3).

HCA should commit to maximizing *ex parte* renewals before sending a renewal form or requesting additional information. This commitment is especially important because Other Adults will face renewals twice as frequently as under the previous annual renewal cycle. HCA should also ensure that requests for additional information are limited to information related to a reported change in circumstances or otherwise necessary to complete the renewal. Proposed NMAC 8.291.410.19(D)(1), (E); 42 C.F.R. § 435.916(d)(1)(i), (e).

HCA's rulemaking notice explains that Other Adults renewals due on or after March 31, 2027 will be subject to the six-month renewal policy because those renewal processes are initiated in January 2027. January and February 2027 Other Adults renewals were initiated before January 1, 2027 and may be renewed for 12 months. N.M. Register, Vol. XXXVII, Issue 15, Notice of Rulemaking (Aug. 11, 2026).

HCA should publish a beneficiary-facing transition plan and provide individualized communication to Other Adults beneficiaries explaining:

- Whether the beneficiary's next renewal is expected to occur under a 12-month or six-month renewal interval.
- The expected date HCA will initiate the individual's next renewal.
- Whether and when HCA will first assess CE for the individual.
- The month or months that may be reviewed for CE.
- How the beneficiary can report a change in circumstances or seek an exclusion or exception.
- How to obtain help before an adverse action occurs.

This communication is especially important because CE requirements apply to applications dated or renewals initiated on or after January 1, 2027. Proposed NMAC 8.296.400.9(F). The federal CE regulations likewise use the date a renewal is initiated in determining when CE verification first applies to people already enrolled at implementation. 42 C.F.R. § 435.559(c).

Federal CE monitoring requirements contemplate review of application and renewal processing, eligibility outcomes, CE compliance, and the need for additional outreach or corrective action. 42 C.F.R. § 435.562. HCA should also report publicly, at least quarterly, on implementation outcomes for Other Adults Medicaid. HCA should report the percentage renewed *ex parte*, the percentage sent renewal forms, procedural terminations, CE notices of noncompliance, CE-related disenrollments, and rates of return to coverage after adverse actions. The information should be disaggregated to the extent permitted by privacy requirements by race, ethnicity, language, disability status, age, county, and managed care organization.

V. HCA should protect continuity of coverage and care before community-engagement-related disenrollment.

The proposed rule requires HCA to continue coverage for enrolled beneficiaries during the CE noncompliance process until the individual is determined ineligible. Proposed NMAC 8.296.400.11(L)(1)(c); 42 C.F.R. § 435.558(a)(3). If an individual does not make a satisfactory showing, HCA must consider all other Medicaid bases of eligibility before determining the person ineligible, provide written notice and fair-hearing rights, and determine potential eligibility for other insurance affordability programs. Proposed NMAC 8.296.400.11(L)(4); 42 C.F.R. §§ 435.558(d), 435.911, 435.1200(e).

HCA should adopt an implementation protocol that makes these protections meaningful for beneficiaries receiving ongoing care. Before disenrolling a beneficiary for CE-related reasons, HCA should ensure that it has completed the required all-bases eligibility review and any assessment for other insurance affordability programs. HCA should also require the adverse-action notice to state:

- The exact date Medicaid coverage will end.
- The specific CE month or months involved.
- The specific facts and reasons supporting the proposed action.
- The individual's fair-hearing rights and instructions for requesting a hearing.
- The availability of assistance with reapplication or transition to other coverage.
- Contact information for HCA and, where available, for enrollment-assistance resources.

HCA should coordinate with its managed care organizations so that beneficiaries facing a CE-related termination receive information about how to avoid interruption in critical care, including prescriptions, behavioral health treatment, pregnancy-related services, and ongoing specialty care. This is an appropriate operational complement to the rule's existing requirements to preserve coverage during the noncompliance process and consider other eligibility and coverage options before termination. Proposed NMAC 8.296.400.11(L)(1), (4); 42 C.F.R. § 435.558(a), (d).

VI. HCA should make address and residency procedures clear to beneficiaries.

Proposed NMAC 8.291.410.27 creates procedures for updated address information, possible out-of-state addresses, and returned mail. For a possible out-of-state address, HCA must make a good-faith effort to contact the beneficiary to determine whether the person continues to meet the state residency requirement. Proposed NMAC 8.291.410.27(C)(1). If HCA cannot confirm continued residency, it must provide advance notice of termination and fair-hearing rights. Proposed NMAC 8.291.410.27(C)(2).

The proposed good-faith effort includes at least two attempts to contact the individual through two or more modalities, reasonable time between attempts, and at least 30 calendar days to respond. Proposed NMAC 8.291.410.27(E). HCA may not update an unconfirmed in-state address or terminate coverage for failure to respond to a request to confirm an address or state residency when the address information has not been confirmed. Proposed NMAC 8.291.410.27(B)(5).

HCA should require that address- and residency-related notices explain these protections in plain language. Proposed NMAC 8.291.410.15(D) recognizes that residence is not abandoned by a temporary absence from New Mexico for a specific, time-limited purpose when the individual intends to return after the purpose is completed. Notices should therefore state that temporary absences for medical care, temporary employment, caregiving, military-related obligations, or other time-limited reasons do not automatically establish loss of New Mexico residency.

Notices should identify the address information HCA received, explain the information needed to resolve the issue, list all response methods, state the deadline, and explain fair-hearing rights. This clarification will help ensure that beneficiaries do not lose coverage based on incomplete third-party information or an inability to promptly respond to an address-verification request.

VII. HCA should make retroactive coverage information available at application.

Proposed NMAC 8.200.400.14 limits retroactive Medicaid coverage for Other Adults to one month before the month of application for applications dated on or after January 1, 2027. Proposed NMAC 8.200.400.14(D). For other listed Medicaid categories, retroactive coverage is limited to up to two months before the month of application. Proposed NMAC 8.200.400.14(E). The rule requires retroactive coverage to be requested within 180 days of the Medicaid application and requires eligibility to be determined separately for each retroactive month. Proposed NMAC 8.200.400.14(A)-(C).

The proposal provides that a person applying in January 2027 for December 2026 Other Adults retroactive coverage does not need to meet CE requirements for that month. For applications dated on or after February 1, 2027, an Other Adults applicant seeking retroactive coverage must satisfy CE requirements for the month before the application month. Proposed NMAC 8.200.400.14(D).

HCA should ensure that application forms, online application screens, eligibility call-center scripts, hospital and provider assister materials, and written notices explain:

- Whether retroactive coverage is available for the applicant's eligibility category.
- The number of prior months potentially available.
- How to request retroactive coverage.
- The 180-day request deadline.
- That eligibility is separately determined for each retroactive month.
- The January 2027 transition rule for December 2026 Other Adults coverage.
- The CE requirement applicable to Other Adults retroactive coverage for applications dated on or after February 1, 2027.

Providing this information at application will help eligible individuals obtain coverage for Medicaid-covered services received before they applied and avoid avoidable medical debt or provider reimbursement problems.

VIII. HCA should establish an accessible process for correcting erroneous death-master-file terminations.

Proposed NMAC 8.200.400.16 requires HCA to review the Social Security Administration death master file no less than quarterly to identify Medicaid beneficiaries who are deceased. If HCA determines that an enrollee is deceased based on that information, it must treat the information as factual, disenroll the individual, and discontinue Medicaid payments other than payments for services provided before death. Proposed NMAC 8.200.400.16(A).

The proposed rule contains an important corrective protection. If HCA determines that a person was misidentified as deceased and was erroneously disenrolled, HCA must reenroll the person retroactively to the date of disenrollment. Proposed NMAC 8.200.400.16(B).

HCA should establish and publicize a beneficiary-facing process for reporting an erroneous death-master-file match and obtaining prompt restoration of coverage. The process should explain:

- Who may report an error, including the beneficiary, an authorized representative, a family member, a provider, a managed care organization, community health worker, or other community stakeholder.
- How an error may be reported by telephone, online, mail, in person, or other available electronic means.
- The information HCA will accept to show the beneficiary was misidentified.
- The expected timeframe for review and correction.
- How the beneficiary, providers, and managed care entities will be notified when coverage is restored.
- That HCA must restore coverage retroactively to the date of disenrollment after determining that the person was misidentified.

Without a clear correction process, beneficiaries and those assisting them may not know why coverage ended or how to access the retroactive reenrollment protection required by the proposed rule.

Thank you for your work and attention to these matters. We appreciate HCA's efforts to implement the required Medicaid changes while maintaining accessible, fair, and accurate processes for New Mexicans applying for and enrolled in Medicaid. Please contact us if we can provide additional information or technical assistance.

Respectfully,

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