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REGULAR MEETING
OF THE
BOARD OF DIRECTORS

March 7, 2023
9:30 AM

CNM Workforce Training Center, Room 207
5600 Eagle Rock Ave. NE, Alb. NM 87113
Online: https://meet.goto.com/NMRHCA/march2023boardmeeting
Telephone: 1-646-749-3122 / Access Code: 728-863-653

New Mexico Retiree Health Care Authority
Annual Meeting

BOARD OF DIRECTORS

ROLL CALL

March 7, 2023

	Member in Attendance		
Mr. Crandall, President			
Ms. Saunders, Vice President			
Ms. Larranaga-Ruffy, Secretary			
Mr. Scroggins			
Mr. Salazar			
Ms. Montoya			
Mr. Widner			
Mr. Bhakta			
Mr. Pyle			
Ms. Alirez			

NMRHCA BOARD OF DIRECTORS

March 2023

Mr. Doug Crandall, President
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14492 E. Sweetwater Ave
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The Honorable Ms. Laura M. Montoya
NM State Treasurer
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Mr. Rick Scroggins
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Educational Retirement Board
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Ms. Raquel Alirez
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Regular Meeting of the
NEW MEXICO RETIREE HEALTH CARE AUTHORITY
BOARD OF DIRECTORS

March 7, 2023
9:30 AM
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Alb. NM 87113
Online: https://meet.goto.com/NMRHCA/march2023boardmeeting
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AGENDA

1.	Call to Order	Mr. Crandall, President	Page
2.	Roll Call to Ascertain Quorum	Ms. Beatty, Recorder	
3.	Pledge of Allegiance	Mr. Crandall, President	
4.	Approval of Agenda	Mr. Crandall, President	4
5.	Approval of Regular Meeting Minutes February 7, 2023	Mr. Crandall, President	5
6.	Public Forum and Introductions	Mr. Crandall, President	
7.	Committee Reports	Mr. Crandall, President	
8.	Executive Director's Updates	Mr. Kueffer, Executive Director	
	a. Human Resources		
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9.	FY23 New Small Contracts (Action Item)	Mr. Kueffer, Executive Director	85
10.	FY23 Financial Audit RFP (Action Item)	Mr. Kueffer, Executive Director	88
11.	IBAC Benefit Plan Comparisons 2023	Mr. Kueffer, Executive Director	89
12.	Other Business	Mr. Crandall, President	
13.	Executive Session	Mr. Crandall, President	

Pursuant to NMSA 1978, Section 10-15-1(H)(2) To Discuss Limited Personnel Matters; NMSA 1978, Section 10-15-1(H)(7) Pertaining to Threatened or Pending Litigation

14. Date & Location of Next Board Meeting — Mr. Crandall, President

TBD
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Alb. NM 87113

15. Adjourn

MINUTES OF THE

NEW MEXICO RETIREE HEALTH CARE AUTHORITY/BOARD OF DIRECTORS

REGULAR MEETING

February 7, 2023

1. CALL TO ORDER

A Regular Meeting of the Board of Directors of the New Mexico Retiree Health Care Authority was called to order on this date at 9:30 a.m. in the PERA Board Room, 33 Plaza La Prensa, Santa Fe, New Mexico.

2. ROLL CALL TO ASCERTAIN A QUORUM

A quorum was present.

Members Present:
Mr. Doug Crandall, President
Ms. Therese Saunders, Vice President
Ms. LeAnne Larrañaga-Ruffy, Secretary
The Hon. Laura Montoya, NM State Treasurer [attending virtually]
Ms. Rachel Alirez
Dr. Tomas Salazar
Mr. Rick Scroggins
Mr. Jamie Widner [attending virtually]

Members Excused:
Mr. Sanjay Bhakta
Mr. Lance Pyle

Staff Present:
Mr. Neil Kueffer, Executive Director
Mr. Keith Witt, Deputy Director
Ms. Sheri Ayanniyi, Chief Financial Officer
Mr. Raymond Long, Chief Information Officer
Ms. Judith Beatty, Recorder

3. PLEDGE OF ALLEGIANCE

Ms. Saunders led the Pledge.

4. APPROVAL OF AGENDA

Ms. Saunders moved for approval of the agenda, as published. Mr. Scroggins seconded the motion, which passed unanimously.

5. APPROVAL OF REGULAR MEETING MINUTES: January 10, 2023

Treasurer Montoya requested that the returns reflected in investment performance reports in future meeting minutes specify realized as well as unrealized gains.

Treasurer Montoya moved for approval of the January 10, 2023, minutes. Dr. Salazar seconded the motion, which passed unanimously.

6. PUBLIC FORUM AND INTRODUCTIONS

Attendees and board members introduced themselves.

7. COMMITTEE REPORTS

- The Executive Committee met last week to approve today's agenda. The Finance Committee also met to discuss today's action items. [Mr. Crandall]

8. EXECUTIVE DIRECTOR'S UPDATES

a) Operations

- The NMRHCA has re-posted the position for general counsel in the *Albuquerque Journal* and *Santa Fe New Mexican.*

- Regarding the prescription drug reporting that was part of the Consolidated Appropriations Act, the NMRHCA and vendors have met the January 31 deadline for submittals. Mr. Kueffer thanked IT staff and the Deputy Director for their work.

Mr. Kueffer cited an article in the Albuquerque Journal over the weekend that addressed the shortage of providers, additional costs related to malpractice, taxes, lower reimbursements for Medicaid, and other issues that the NMRHCA struggles with as it works to provide an adequate network to its members so they can get care when they need it. Unfortunately, the shortage of doctors over the years is a trend that has been ongoing since 2017.

Dr. Salazar said it would be helpful to know how big the trend is in terms of numbers and what the NMRHCA board might do to attract doctors to the state.

Mr. Kueffer responded that the article stated that, in 2021, there were 1,649 primary care physicians in New Mexico, 700 fewer than in 2017. During the same time period, New Mexico lost 63 OB-GYNs, and there are now 219 in the state, 59 fewer than the national benchmark.

Speaking to Dr. Salazar's concerns, Mr. Kueffer said the NMRHCA would work with the health plans to see what information they could provide. This is also something the NMRHCA needs to look at not just in terms of numbers, but also in terms of quality of care to make sure the members are receiving the best. While the agency strives to add more to the networks, it wants to make sure it doesn't lose sight of the quality of care that is being provided. He said he hoped to provide some updates to the board.

Responding to Dr. Salazar, Mr. Kueffer said the article cited a doctor who pays $65,000 a year for his malpractice insurance in New Mexico, while coverage in Colorado and Arizona would be $18,000 and in Texas $38,000. This is partly due to a larger proportion of Medicaid recipients in New Mexico, which translates into lower reimbursements and higher rates from providers to try to make up some of the difference.

Treasurer Montoya suggested to Mr. Kueffer that this would be a good time to include something in *Round the Roundhouse*, as the legislature is currently in session.

b) <u>Legislative</u>

- House Bill 150, sponsored by Rep. Figueroa, is in the board book for review along with a Fiscal Impact Report. It was determined in the first committee review that some numbers cited in the synopsis were off in terms of employee-employer percentage increases. The bill passed the first committee and will next go to the House Appropriations and Finance Committee.

Mr. Kueffer reviewed the FY24/LFC Executive Recommendation Comparison, highlighting the FY23 approved operating budget, FY24 appropriation request, and corresponding recommendations made by the LFC and Executive.

- Under Healthcare Benefits Administration, the NMRHCA's request for contractual services increases for benefits plans was met by both agencies.

- Under personal services and employee benefits, both recommendations were lower than the NMRHCA's request. The LFC recommended one out of the three FTEs requested. Based on the House Appropriations Committee's action to approve the LFC's recommendation, staff does not anticipate the Senate will change that and the NMRHCA will likely end up with just one of the three requested FTEs.

- Under Contractual Services, DFA had granted the NMRHCA its full ask; however, the LFC reduced the amount. One item of strong interest to the board is to bring in a

financial advisor on a regular basis; this can be accommodated within the approved FY24 budget.

- Neither recommendation included support for the requested special appropriation of $26 million to be added to the trust fund.

c) December 31, 2022, SIC Reports

- Gains – Realized & Unrealized were ($16.7) million; Market Value was $1.127 billion.

9. FY23 SECOND QUARTER BUDGET REPORT

Ms. Ayanniyi presented this report.

10. FIVE YEAR STRATEGIC PLAN

Mr. Kueffer reviewed highlights from the proposed NMRHCA 5-Year Strategic Plan for 2023-2027 and requested approval.

Chairman Crandall noted that these are strategic plan guidelines, as opposed to actual strategies, that the board implements annually. The details come up later at the board's annual meeting in July.

Treasurer Montoya suggested that "Increase employee/employer contribution levels" under Legislative Action (item 7) be amended to cite legislation that assists NMRHCA to become solvent.

Mr. Kueffer said he would include this as an overarching item with bullet points to address an increase in the employee/employer contribution levels as well as a special appropriation.

Treasurer Montoya noted earlier comments by Chairman Crandall about an internal financial advisory system. She said this is very expensive software, and suggested including that in the strategic plan under a goal such as "continuity of growth with employees for service."

Treasurer Montoya moved to adopt the 5-Year Strategic Plan for 2023-2027 with Item 7 worded as "legislation and strategy that assists the NMRHCA to become solvent." Ms. Alirez seconded the motion, which passed unanimously.

11. OUT-OF-STATE TRAVEL REQUEST

Mr. Kueffer stated that Express Scripts has extended an invitation to NMRHCA to attend the Government Advisory Panel (GAP) and Express Scripts Outcomes Symposium. This is a conference that board members and staff have attended before to learn about the pharmacy industry,

specialty medications, strategies on combating opioid use and abuse, networks, cost containment strategies, and gene therapy.

Mr. Kueffer noted that the conference takes place on May 2-5 in Orlando, Florida. This presents a conflict with the usual NMRHCA meeting schedule, which takes place on the first Tuesday of each month. He asked the board for guidance, stating that he would be happy to send the Deputy Director to the meeting in his stead in order that he be present at the board meeting.

Chairman Crandall commented that this is a very good conference and he would highly recommend it.

Dr. Salazar moved for approval. Ms. Larrañaga-Ruffy seconded the motion.

Chairman Crandall recommended that discussion on the May board meeting date take place at a future meeting when more board members are present.

The motion passed unanimously.

12. OTHER BUSINESS

Mr. Kueffer stated that he along with two staff members would be attending the SALGBA conference on April 2-5 in New Orleans. He noted that the conference would be taking place during the April board meeting.

Chairman Crandall recommended discussing the idea of an annual calendar at the March board meeting.

13 EXECUTIVE SESSION

None.

14. DATE AND LOCATION OF NEXT BOARD MEETING

March 7, 2023 – 9:30 a.m.
CNM Workforce Training Center
5600 Eagle Rock Ave NE, Albuquerque NM 87113

15. ADJOURN 10:42

Accepted by:

_____

Doug Crandall, President

2/23/23

Humana to Exit Employer Group Commercial Medical Products Business

LOUISVILLE, Ky.--(BUSINESS WIRE)-- Humana Inc. (NYSE: HUM) today announced that it will be exiting the Employer Group Commercial Medical Products business, which includes all fully insured, self-funded and Federal Employee Health Benefit medical plans, as well as associated wellness and rewards programs. No other Humana health plan offerings are materially affected. The company remains committed to the long-term growth of its core Insurance lines of business, including Medicare Advantage, Group Medicare, Medicare Supplement, Medicare Prescription Drug Plans, Medicaid, Military and Specialty (Dental, Vision, Life, etc.), as well as its CenterWell healthcare services business.

Following a strategic review, the company determined that the Employer Group Commercial Medical Products business was no longer positioned to sustainably meet the needs of commercial members over the long term or support the company's long-term strategic plans. The exit from this line of business will be phased over the next 18 to 24 months. The company is committed to ensuring a smooth transition of services for members and commercial customers.

"This decision enables Humana to focus resources on our greatest opportunities for growth and where we can deliver industry leading value for our members and customers," said Bruce D. Broussard, Humana's President and Chief Executive Officer. "It is in line with the company's strategy to focus our health plan offerings primarily on Government-funded programs (Medicare, Medicaid and Military) and Specialty businesses, while advancing our leadership position in integrated value-based care and expanding our CenterWell healthcare services capabilities. We are confident in Humana's continued success, and our commitment to improving the health of those we serve is unwavering."

Financial results for Employer Group Commercial Medical Products will be adjusted for non-GAAP purposes going forward and are not expected to impact the company's full year 2023 Adjusted earnings per share (EPS) guidance.

Based on the seasonality of Employer Group Commercial Medical Products earnings, the company now expects first-quarter 2023 earnings to represent approximately 33 percent of full-year 2023 Adjusted EPS, after considering the non-GAAP treatment of the Employer Group Commercial Medical business. This compares to the approximately 35 percent estimate previously disclosed, which did not take into account the non-GAAP treatment of Employer Group Commercial Medical earnings.

Further, due to this seasonality dynamic, the non-GAAP treatment of Employer Group Commercial Medical results is also anticipated to increase the first-quarter 2023 Insurance segment benefit ratio by approximately 30 basis points, with no impact expected on the full-year 2023 Insurance segment benefit ratio.

About Humana

Humana Inc. (NYSE: HUM) is committed to helping our millions of medical and specialty members achieve their best health. Our successful history in care delivery and health plan administration is helping us create a new kind of integrated care with the power to improve health and well-being and lower costs. Our efforts are leading to a better quality of life for people with Medicare, families, individuals, military service personnel, and communities at large.

To accomplish that, we support physicians and other health care professionals as they work to deliver the right care in the right place for their patients, our members. Our range of clinical capabilities, resources and tools – such as in-home care, behavioral health, pharmacy services, data analytics and wellness solutions – combine to produce a simplified experience that makes health care easier to navigate and more effective.

More information regarding Humana is available to investors via the Investor Relations page of the company's website at humana.comopens new window, including copies of:

- Annual reports to stockholders;
- Securities and Exchange Commission filings;
- Most recent investor conference presentations;
- Quarterly earnings news releases and conference calls;
- Calendar of events; and
- Corporate Governance information.

Humana Cautionary Statement

This news release includes forward-looking statements regarding Humana within the meaning of the Private Securities Litigation Reform Act of 1995. When used in investor presentations, press releases, Securities and Exchange Commission (SEC) filings, and in oral statements made by or with the approval of one of Humana's executive officers, the words or phrases like "expects," "believes," "anticipates," "intends," "likely will result," "estimates," "projects" or variations of such words and similar expressions are intended to identify such forward-looking statements. These forward-looking statements are not guarantees of future performance and are subject to risks, uncertainties, and assumptions, including, among other things, information set forth in the "Risk Factors" section of the company's SEC filings.

Presbyterian plans joint move with Iowa-based health system

BY MATTHEW NARVAIZ / JOURNAL STAFF WRITER
PUBLISHED: THURSDAY, MARCH 2ND, 2023 AT 5:18PM
UPDATED: THURSDAY, MARCH 2ND, 2023 AT 5:44PM

Presbyterian Healthcare Services, which manages the Presbyterian Hospital in Downtown Albuquerque, is looking to create a parent organization with Iowa-based UnityPoint Health to consolidate administrative functions and ease cost burdens for the two health systems. (Chancey Bush/Journal)

Facing unrelenting fiscal pressures, Presbyterian Healthcare Services on Thursday announced it is exploring the formation of a parent organization with Iowa-based

UnityPoint Health to consolidate administrative functions and ease cost burdens on both not-for-profit health systems.

President and CEO Dale Maxwell said patients will not be affected by the change. Jobs related to patient care and the health plan will not be affected. He added that it's too soon to tell what – or if – jobs will be impacted on the administrative side for PHS.

But the creation of a parent organization is still in the early stages and requires the health systems to notify and receive approval from the state Attorney General's Office, the Federal Trade Commission and the IRS.

Maxwell said PHS lost $105 million in 2022, leading the board of directors to explore options to reduce costs. He characterized the health system's challenges as structural, not cyclical.

"The challenges … are not going away," Maxwell said. "It's not something we can weather the storm for the next one year or two years and think that we're going to go back to pre-pandemic levels. These changes are going to be with us well into the future."

Under the new parent organization, which has yet to be named, administrative functions of the two health systems would come together under one roof, reducing duplication and promoting greater efficiency, Maxwell said.

That includes possibly combining the administrative overhead of the two health systems, Maxwell said. But it also includes combining online systems such as electronic health records. Both UnityPoint and PHS use Epic for electronic medical records – a cost that, under the new organization, could be shared to provide savings for the two health systems.

"You can gain significant savings and opportunities out of doing that," Maxwell said. "If you think of an organization of this size, we have many types of those software platforms that we can combine and share across each individual market."

The streamlining of administrative costs and the resulting efficiencies and savings, Maxwell said, means UnityPoint and PHS could better invest in workforce development and clinical excellence. But, he said, it's too early to say how much money forming the parent organization could save the two health systems.

The bringing together of UnityPoint and Presbyterian could mean a sizable footprint for the yet-to-be formed health system.

PHS, which includes Presbyterian Health Plan and Presbyterian Delivery System, serves more than 900,000 patients across the state. The health system also has nine hospitals spread across New Mexico, a score of clinics and roughly 13,000 employees. Presbyterian Health Plan – the health care insurance arm of PHS – has some 650,000 enrollees.

UnityPoint has operations in Iowa, Illinois and Wisconsin.

Combined, the parent organization would oversee approximately 4 million patients at more than 40 hospitals and hundreds of clinics. The workforce under the parent organization would increase to some 40,000 which includes thousands of physicians, PHS said.

“UnityPoint Health and Presbyterian are two organizations rooted in similar values,” said UnityPoint President and CEO Clay Holderman, who spent more than a decade with Presbyterian. “By lowering administrative costs, building new capabilities and increasing investments in innovation and clinical excellence, our intent is to help improve affordability and accessibility of care. We’re excited about the unique possibilities ahead.”

https://www.abqjournal.com/2577939/presbyterian-plans-joint-move-with-iowabased-health-system.html

Fact sheet

CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency

Feb 27, 2023 Hospitals, Medicaid & CHIP, Telehealth

Based on current COVID-19 trends, the Department of Health and Human Services is planning for the federal Public Health Emergency for COVID-19 (PHE), declared under Section 319 of the Public Health Service Act, to expire at the end of the day on May 11, 2023. Thanks to the Administration's whole-of-government approach to combatting the virus, we are in a better place in our response than we were three years ago, and we can transition away from an emergency phase.

The emergency declarations, legislative actions by Congress, and regulatory actions across government, including by the Centers for Medicare & Medicaid Services (CMS), allowed for changes to many aspects of health care delivery during the COVID-19 PHE. Health care providers received maximum flexibility to streamline delivery and allow access to care during the PHE. While some of these changes will be permanent or extended due to Congressional action, some waivers and flexibilities will expire, as they were intended to respond to the rapidly evolving pandemic, not to permanently replace standing rules.

This fact sheet will help you know what to expect at the end of the PHE so that you can continue to feel confident in how you will receive your health care. Please note that this information is not intended to cover every possible scenario.

This fact sheet will cover the following:

- COVID-19 vaccines, testing, and treatments;
- Telehealth services;
- Health Care Access: Continuing flexibilities for health care professionals; and
- Inpatient Hospital Care at Home: Expanded hospital capacity by providing inpatient care in a patient's home.

The Administration, States, and private insurance plans will continue to provide guidance in the coming months. As described in previous communications, the Administration's continued response is not entirely dependent on the COVID-19 PHE. There are significant

flexibilities and actions that will not be affected as we transition from the current phase of our response. For more information on what changes and does not change across the Department, visit https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.

COVID-19 vaccines, testing, and treatments

Medicare

Vaccines: People with Medicare coverage will continue to have access to COVID-19 vaccinations without cost sharing after the end of the PHE.

Testing: Additionally, people with traditional Medicare can continue to receive COVID-19 PCR and antigen tests with no cost sharing when the test is ordered by a physician or certain other health care providers, such as physician assistants and certain registered nurses, and performed by a laboratory. People enrolled in Medicare Advantage (MA) plans can continue to receive COVID-19 PCR and antigen tests when the test is covered by Medicare, but their cost-sharing may change when the PHE ends. By law, Medicare does not generally cover over-the-counter services and tests. Current access to free over-the-counter COVID-19 tests will end with the end of the PHE. However, some Medicare Advantage plans may continue to provide coverage as a supplemental benefit.

Treatments: There is no change in Medicare coverage of treatments for those exposed to COVID-19 once the PHE ends, and in cases where cost sharing and deductibles apply now, they will continue to apply. Generally, the end of the COVID-19 PHE does not change access to oral antivirals, such as Paxlovid and Lagevrio.

Medicaid and CHIP

Vaccines, Testing, and Treatment: As a result of the *American Rescue Plan Act of 2021 (ARPA)*, states must provide Medicaid and CHIP coverage without cost sharing for COVID-19 vaccinations, testing, and treatments through the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. If the COVID-19 PHE ends as expected on May 11, 2023, this coverage requirement will end on September 30, 2024.

After that date, many Medicaid and CHIP enrollees will continue to have coverage for COVID-19 vaccinations. After the *ARPA* coverage requirements expire, Medicaid and CHIP coverage of COVID-19 treatments and testing may vary by state.

Additionally, 18 states and U.S. territories have opted to provide Medicaid coverage to uninsured individuals for COVID-19 vaccinations, testing, and treatment. Under federal law,

Medicaid coverage of COVID-19 vaccinations, testing, and treatment for this group will end when the PHE ends.

Private Health Insurance

Vaccines: Most forms of private health insurance must continue to cover COVID-19 vaccines furnished by an in-network health care provider without cost sharing. People with private health insurance may need to pay part of the cost if an out-of-network provider vaccinates them.

Testing: After the expected end of the PHE on May 11, 2023, mandatory coverage for over-the-counter and laboratory-based COVID-19 PCR and antigen tests will end, though coverage will vary depending on the health plan. If private insurance chooses to cover these items or services, there may be cost sharing, prior authorization, or other forms of medical management may be required.

Treatments: The transition forward from the PHE will not change how treatments are covered, and in cases where cost sharing and deductibles apply now, they will continue to apply.

Access to Telehealth Services

Medicare and Telehealth

During the PHE, individuals with Medicare had broad access to telehealth services, including in their homes, without the geographic or location limits that usually apply as a result of waivers issued by the Secretary, facilitated by the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020,* and the *Coronavirus Aid, Relief, and Economic Security Act*. "Telehealth" includes services provided through telecommunications systems (for example, computers and phones) and allows health care providers to give care to patients remotely in place of an in-person office visit.

The *Consolidated Appropriations Act, 2023,* extended many telehealth flexibilities through December 31, 2024, such as:

- People with Medicare can access telehealth services in any geographic area in the United States, rather than only those in rural areas.
- People with Medicare can stay in their homes for telehealth visits that Medicare pays for rather than traveling to a health care facility.
- Certain telehealth visits can be delivered audio-only (such as a telephone) if someone is unable to use both audio and video, such as a smartphone or computer.

Medicare Advantage plans may offer additional telehealth benefits. Individuals in a Medicare Advantage plan should check with their plan about coverage for telehealth services. Additionally, after December 31, 2024 when these flexibilities expire, some Accountable Care Organizations (ACOs) may offer telehealth services that allow primary care doctors to care for patients without an in-person visit, no matter where they live. If your health care provider participates in an ACO, check with them to see what telehealth services may be available.

Medicaid, CHIP, and Telehealth

For Medicaid and CHIP, telehealth flexibilities are not tied to the end of the PHE and have been offered by many state Medicaid programs long before the pandemic. Coverage will ultimately vary by state. CMS encourages states to continue to cover Medicaid and CHIP services when they are delivered via telehealth.

To assist states with the continuation, adoption, or expansion of telehealth coverage, CMS has released the State Medicaid & CHIP Telehealth Toolkit and a supplement that identifies for states the policy topics that should be addressed to facilitate widespread adoption of telehealth: https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit-supplement1.pdf.

Private Health Insurance and Telehealth

As is currently the case during the PHE, coverage for telehealth and other remote care services will vary by private insurance plan after the end of the PHE. When covered, private insurance may impose cost-sharing, prior authorization, or other forms of medical management on telehealth and other remote care services.

For additional information on your insurer's approach to telehealth, contact your insurer's customer service number located on the back of your insurance card.

COVID-19 Waivers and Administrative Flexibilities: How Health Care Providers and Suppliers are Affected

For specific details about how health care providers and suppliers should prepare for the end of the COVID-19 PHE, CMS has developed a series of provider-specific fact sheets at https://www.cms.gov/coronavirus-waivers. Below are items of high interest that affect many providers.

Standard Blanket Waivers for Disaster Responses

Blanket waivers generally apply to all entities in a provider category (e.g., all hospitals); these waivers have been made available to several categories of providers and will end at the end of the PHE.

CMS typically issues a standard group of "blanket waivers" in response to emergencies or natural disasters. These can include, for example:

- Waivers of the requirement for three-day prior inpatient hospitalization for Medicare coverage of a skilled nursing facility stay;
- Waivers of the requirements that Critical Access Hospitals (CAHs) limit the number of inpatient beds to 25 and general limitations on CAH lengths of stay to no longer than 96 hours on average;
- Waivers to allow acute care patients to be housed in other facilities, such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories;
- Other waivers.

These waivers were intended to temporarily expand health care capacity when needed and generally cannot be made permanent without a legislative change. Additional information about what blanket waivers were made available during the COVID-19 PHE is available here: https://www.cms.gov/coronavirus-waivers.

Hospital at Home

In response to the challenges faced by hospitals because of COVID-19, CMS implemented the Acute Hospital Care at Home initiative, a flexibility to allow hospitals to expand their capacity to provide inpatient care in an individual's home. Many hospitals and individuals participated in this initiative – there is broad geographic distribution of hospitals participating, ranging in size and services from small rural settings to large academic settings. The number of approved hospitals in each state varies.

Under the *Consolidated Appropriations Act, 2023*, the Acute Hospital Care at Home initiative has been extended through December 31, 2024. Hospitals can continue to apply to participate in the initiative. If an individual is receiving care in a participating hospital and meets the requirements to receive inpatient care at home, they can continue to do so.

Nurse Aide Training for Nursing Homes

To help nursing homes address staffing shortages during the pandemic, CMS provided a blanket waiver for the nurse aide training and certification requirements to permit nurse aides to work for longer than four months without completing their training. As these nurse aides provided much-needed care, this waiver allowed facilities to employ individuals beyond four months in a nurse aide role even though they might not have completed a

state-approved Nurse Aide Training and Competency Evaluation Programs (NATCEP) or Competency Evaluation Program (CEP).

CMS ended this waiver in 2022 and noted that it is critical for aides to be trained and certified so they have the skills to meet nursing home residents' needs. However, in cases where barriers to certification existed due to workforce shortages, CMS granted individual, time-limited waivers to help facilities retain staff while continuing to seek training and certification.

All nursing aide training emergency waivers for states and facilities will end at the end of the PHE, which is expected on May 11, 2023. At that time, facilities will have four months (i.e., until September 10, 2023) to have all nurse aides who are hired prior to the end of the PHE complete a state-approved NATCEP/CEP. Nurse aides hired after the end of the PHE will have up to four months from their date of hire to complete a state-approved NATCEP/CEP.

Virtual Supervision

To allow more people to receive care during the PHE, CMS temporarily changed the definition of “direct supervision” to allow the supervising health care professional to be immediately available through virtual presence using real-time audio/video technology instead of requiring their physical presence. CMS also clarified that the temporary exception to allow immediate availability for direct supervision through virtual presence also facilitates the provision of telehealth services by clinical staff “incident to” the professional services of physicians and other practitioners. This flexibility will expire on December 31, 2023.

Scope of Practice

Certified Registered Nurse Anesthetist - Anesthesia services

CMS currently waives the requirement that a certified registered nurse anesthetist (CRNA) must be under the supervision of a physician, instead permitting CRNA supervision at the discretion of the hospital or Ambulatory Surgical Center (ASC) and state law. This waiver applies to hospitals, CAHs, and ASCs. These waivers allow CRNAs to function to the fullest extent of their licensure when this is occurring consistent with a state or pandemic or emergency plan.

CMS will end this emergency waiver at the end of the PHE, which is expected to be on May 11, 2023, but states may apply to waive the requirement. To apply for an exemption in a state, based on the standards set forth in the final rule published on November 13, 2001 (66 Fed. Reg. 56762), the Governor of the state must send a request to CMS. In the letter,

the Governor of the state must attest that they consulted with the State Boards of Medicine and Nursing about issues related to access to and quality of anesthesia services and concluded that it is in the best interest of the citizens of the state to opt-out of the current supervision requirements and that the opt-out is consistent with state law.

Health and Safety Requirements

A significant number of emergency waivers related to health and safety requirements will expire at the end of the PHE, which is expected to be on May 11, 2023. For example, during the PHE, the time frame to complete a medical record at discharge was extended because the large volume of patients being treated would result in the clinician being away from direct patient care for extended periods of time. Typically, a patient's medical records are required to be completed at discharge to ensure there are no gaps in patients' continuity of care. This means each provider should have the most up-to-date understanding of their patients' medical records.

Medicaid Continuous Enrollment Condition

The continuous enrollment condition for individuals enrolled in Medicaid is no longer linked to the end of the PHE. Under the *Families First Coronavirus Response Act*, states claiming a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP) have been unable to terminate enrollment for most individuals enrolled in Medicaid as of March 18, 2020, as a condition of receiving the temporary FMAP increase.

As part of the *Consolidated Appropriations Act, 2023*, the continuous enrollment condition will end on March 31, 2023. The temporary FMAP increase will be gradually reduced and phased down beginning April 1, 2023 (and will end on December 31, 2023). For more information, visit Medicaid.gov/unwinding.

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SENATE BILL 14

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

Elizabeth "Liz" Stefanics and Elizabeth "Liz" Thomson

AN ACT

RELATING TO INSURANCE; AMENDING AND ENACTING SECTIONS OF THE PHARMACY BENEFITS MANAGER REGULATION ACT; ADDING NEW REQUIREMENTS FOR RENEWAL OF PHARMACY BENEFITS MANAGER LICENSES; REQUIRING DISCLOSURE OF DOCUMENTS DURING AN INVESTIGATION; REQUIRING TRANSPARENCY IN PHARMACY BENEFITS REIMBURSEMENT; PROVIDING FOR CONFIDENTIALITY; PROVIDING FOR CHANGES IN THE REIMBURSEMENT PROCESS; ADDRESSING THE APPEALS PROCESS; REQUIRING THE PROVISION OF CERTAIN INFORMATION UPON REQUEST; REQUIRING THE INCLUSION OF CERTAIN CONTRACT PROVISIONS; LIMITING CHARGES TO THOSE ITEMIZED IN A CONTRACT; ADDRESSING COST SHARING; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 59A-61-2 NMSA 1978 (being Laws 2014, Chapter 14, Section 2, as amended) is amended to read:

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"59A-61-2. DEFINITIONS.--As used in the Pharmacy Benefits Manager Regulation Act:

A. "health benefits plan" means a policy or agreement entered into or offered or issued by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services; provided that "health benefits plan" does not include any of the following:

(1) an accident-only policy;

(2) a credit-only policy;

(3) a long- or short-term care or disability income policy;

(4) a specified disease policy;

(5) coverage provided pursuant to Title 18 of the federal Social Security Act, as amended;

(6) coverage provided pursuant to Title 19 of the federal Social Security Act and the Public Assistance Act;

(7) a federal TRICARE policy, including a federal civilian health and medical program of the uniformed services supplement;

(8) a fixed or hospital indemnity policy;

(9) a dental-only policy;

(10) a vision-only policy;

(11) a workers' compensation policy;

(12) an automobile medical payment policy; or

(13) any other policy specified in rules of

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the superintendent;

B. "insured" means an individual who is entitled to receive health care benefits provided by a health benefits plan;

C. "insurer" means a health insurance plan or multiple welfare arrangement subject to the Health Care Purchasing Act, Chapter 59A, Article 22 or 23 NMSA 1978, the Health Maintenance Organization Law or the Nonprofit Health Care Plan Law;

[~~A.~~] D. "maximum allowable cost" means the maximum amount that a pharmacy benefits manager will reimburse a pharmacy for the cost of a generic drug;

[~~B.~~] E. "maximum allowable cost list" means a searchable, electronic and internet-based listing of drugs used by a pharmacy benefits manager setting the maximum allowable cost on which reimbursement to a pharmacy or pharmacist is made;

[~~C.~~] F. "obsolete" means a product that is listed in national drug pricing compendia but is no longer available to be dispensed based on the expiration date of the last lot manufactured;

[~~D.~~] G. "pharmacist" means an individual licensed as a pharmacist by the board of pharmacy;

[~~E.~~] H. "pharmacy" means a licensed place of business where drugs are compounded or dispensed and pharmacist

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services are provided;

[~~F.~~] I. "pharmacy benefits management" means a service provided to or conducted by [~~a health plan as defined in Section 59A-16-21.1 NMSA 1978~~] an insurer or [~~health insurer~~] plan sponsor that involves:

(1) prescription drug claim administration;

(2) pharmacy network management;

(3) negotiation and administration of prescription drug discounts, rebates and other benefits;

(4) design, administration or management of prescription drug benefits;

(5) formulary management;

(6) payment of claims to pharmacies for dispensing prescription drugs;

(7) negotiation or administration of contracts relating to pharmacy operations or prescription benefits; or

(8) any other service determined by the superintendent as specified by rule to be a pharmacy benefits management activity;

[~~G.~~] J. "pharmacy benefits manager" means an entity that provides pharmacy benefits management services;

[~~H.~~] K. "pharmacy benefits manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one or more intermediaries, owns or controls, is owned or controlled by or is under common ownership or control with a

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pharmacy benefits manager;

[~~I.~~] L. "pharmacy services administrative organization" means an entity that contracts with a pharmacy or pharmacist to act as the pharmacy or pharmacist's agent with respect to matters involving a pharmacy benefits manager or third-party payor, including negotiating, executing or administering contracts with the pharmacy benefits manager or third-party payor; [~~and~~

~~J. "superintendent" means the superintendent of insurance.~~]

M. "plan sponsor" means an employer organization that offers group health plans to its employees or members;

N. "rebate" means all price concessions paid by a manufacturer to a pharmacy benefits manager or insurer that are based on the:

(1) actual or estimated use of a prescription drug; or

(2) effectiveness of a prescription drug pursuant to the terms of a value-based or performance-based contract; and

O. "spread pricing" means the model of prescription drug pricing in which a pharmacy benefits manager charges a health benefits plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager directly or

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indirectly pays a pharmacist or pharmacy for pharmacist services."

SECTION 2. Section 59A-61-3 NMSA 1978 (being Laws 2014, Chapter 14, Section 3, as amended) is amended to read:

"59A-61-3. LICENSURE--INITIAL APPLICATION--ANNUAL RENEWAL REQUIRED--REVOCATION.--

A. A person shall not operate as a pharmacy benefits manager unless licensed by the superintendent in accordance with the Pharmacy Benefits Manager Regulation Act and applicable federal and state laws. A licensee shall renew the licensee's pharmacy benefits manager license annually.

B. An initial application and a renewal application for licensure as a pharmacy benefits manager shall be made on a form and in a manner provided for by the superintendent, but at a minimum shall require:

(1) the identity of the pharmacy benefits manager;

(2) the name and business address of the contact person for the pharmacy benefits manager;

(3) where applicable, the federal employer identification number for the pharmacy benefits manager; and

(4) any other information specified in rules promulgated by the superintendent.

C. The superintendent shall enforce and promulgate rules to implement the provisions of the Pharmacy Benefits

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Manager Regulation Act and may suspend or revoke a license issued to a pharmacy benefits manager or deny an application for a license or renewal of a license if:

(1) the pharmacy benefits manager is operating in contravention of its application;

(2) the pharmacy benefits manager has failed to continuously meet or comply with the requirements for issuance or maintenance of a license; or

(3) the pharmacy benefits manager has failed to comply with applicable state or federal laws or rules.

D. If the license of a pharmacy benefits manager is revoked, the manager shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs, notify each pharmacy in its network and conduct no further pharmacy benefits management services in the state, except as may be essential to the orderly conclusion of its affairs. The superintendent may permit further operation of the pharmacy benefits manager if the superintendent finds it to be in the best interest of patients.

E. [~~A person~~] An entity whose pharmacy benefits manager license has been denied, suspended or revoked may seek review of the denial, suspension or revocation pursuant to the provisions of Chapter 59A, Article 4 NMSA 1978.

F. Nothing in the Pharmacy Benefits Manager Regulation Act shall be construed to authorize a pharmacy

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benefits manager to transact the business of insurance.

G. A pharmacy benefits manager that subcontracts with another pharmacy benefits manager to perform pharmacy benefits management services shall be independently licensed and comply with the provisions of the Pharmacy Benefits Manager Regulation Act.

H. The superintendent shall not require a licensed pharmacy benefits manager to also be licensed as an insurance administrator pursuant to Chapter 59A, Article 12A NMSA 1978, unless the pharmacy benefits manager provides insurance administration services beyond the scope of the Pharmacy Benefits Manager Regulation Act.

I. An entity licensed as a pharmacy benefits manager shall comply with the applicable provisions of Chapter 59A, Articles 12 and 12A NMSA 1978, unless the entity provides insurance administration.

J. As a condition of licensure, the superintendent may require a pharmacy benefits manager to report compliance with any portion of the Pharmacy Benefits Manager Regulation Act in a time and manner required by rule."

SECTION 3. Section 59A-61-4 NMSA 1978 (being Laws 2014, Chapter 14, Section 4, as amended) is amended to read:

"59A-61-4. PHARMACY REIMBURSEMENT PRACTICES FOR [~~GENERIC~~] DRUGS--APPEALS PROCESS REQUIRED.--

A. A pharmacy benefits manager shall determine a

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reimbursement amount for a [~~generic~~] drug based on objective and verifiable sources.

B. A pharmacy benefits manager shall reimburse a pharmacy an amount no less than the amount that the pharmacy benefits manager reimburses itself or a pharmacy benefits manager affiliate in the same network for providing the same or equivalent service. The amount shall be calculated on a per-unit basis using the same generic product identifier or generic code number.

C. A pharmacy benefits manager using maximum allowable cost pricing may place a drug on a maximum allowable cost list if the drug:

(1) is listed as "A" or "B" rated in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence evaluations, also known as the "orange book", or has an "NR" or "NA" rating or a similar rating by a nationally recognized reference;

(2) is available for purchase by pharmacies in the state at the time of claim submission from national or regional wholesalers and is not obsolete; and

(3) is a drug with not fewer than two "A" or "B" rated therapeutically equivalent drugs in the most recent version of the United States food and drug administration's approved drug products with therapeutic equivalence

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evaluations, also known as the "orange book".

D. A pharmacy benefits manager using maximum allowable cost pricing shall:

(1) upon a network pharmacy's request, provide that network pharmacy with the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(2) review and update maximum allowable cost price information at least once every seven business days to reflect any modification of maximum allowable cost pricing;

(3) establish and maintain a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in at least seven business days to remain consistent with pricing changes and product availability in the marketplace;

(4) provide a procedure that allows a pharmacy to choose the entity to which it will appeal reimbursement for generic drugs. A pharmacy may appeal:

(a) directly to the pharmacy benefits manager; or

(b) through a pharmacy services administrative organization;

(5) provide an appeals process that, at a minimum, includes the following:

(a) a dedicated telephone number and

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electronic mail address or website for the purpose of submitting appeals;

(b) the ability to submit an appeal directly to the pharmacy benefits manager; and

(c) the allowance of at least twenty-one business days to file an appeal after the date a pharmacy receives notice of the reimbursement amount;

(6) grant an appeal if the pharmacy benefits manager fails to respond to a complete submission as defined by rules promulgated by the superintendent of the appealing party in writing within fourteen business days after the pharmacy benefits manager receives the appeal;

(7) if an appeal is granted, notify the challenging pharmacy and its pharmacy services administrative organization, if any, in writing, that the appeal is granted and make the change in the maximum allowable cost effective for the appealing pharmacy and for each other pharmacy in its network and permit the appealing pharmacy to reverse and bill again the claim or claims that formed the basis of the appeal;

(8) when an appeal is denied, provide the challenging pharmacy and its pharmacy services administrative organization, if any, the national drug code number and supplier that has the product available for purchase in New Mexico at or below the maximum allowable cost;

(9) within one business day of granting or

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denying a network pharmacy's appeal, notify all network pharmacies and the pharmacy services administration organization of the decision;

(10) upon granting an appeal, allow other similarly situated network pharmacies to reverse and bill again for like claims that formed the basis of the granted appeal; [~~and~~]

(11) provide for each of its network pharmacy providers and the superintendent a process and mechanism to readily access the maximum allowable cost list specific to that provider; and

(12) allow a pharmacy to file an exemption request to a maximum allowable cost denial or when the national average drug wholesale acquisition cost and the average sales price maximum allowable cost are unavailable to the pharmacy.

E. The superintendent may hear and resolve any dispute between a pharmacy benefits manager and a pharmacy after all internal appeals processes provided by the pharmacy benefits manager have been exhausted.

F. A pharmacy benefits manager shall not:

(1) reimburse a pharmacy or pharmacist for a prescription drug or pharmacy service in an amount less than the:

(a) national average drug acquisition cost; or

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(b) if the drug is unavailable at the cost pursuant to Subparagraph (a) of this paragraph, at the time the drug is administered or dispensed, the wholesale acquisition cost of the drug, as defined in 42 U.S.C. Section 1395w-3a(c)(6)(B);

(2) provide a professional dispensing fee of less than ten dollars forty-nine cents ($10.49) per drug; or

(3) calculate a reimbursement amount as of any date other than the date that the pharmacist dispensed or administered the drug.

[~~E.~~] G. A maximum allowable cost list specific to a provider and maintained by a [~~managed care organization~~] health benefits plan or pharmacy benefits manager is confidential.

[~~F.~~] H. Pursuant to Section 59A-4-3 NMSA 1978, a pharmacy benefits manager shall provide information contained in a maximum allowable cost list or the purchase prices negotiated and the prices paid to pharmacies in and out of network to the superintendent upon request by the superintendent.

I. A pharmacy benefits manager or representative of a pharmacy benefits manager shall not make or permit any reduction of payment for pharmacist services by a pharmacy benefits manager or a health care payer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand

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effective rates, direct and indirect remuneration fees or any other reduction or aggregate reduction of payment."

SECTION 4. Section 59A-61-5 NMSA 1978 (being Laws 2014, Chapter 14, Section 5, as amended) is amended to read:

"59A-61-5. PHARMACY BENEFITS MANAGER CONTRACTS--CERTAIN PRACTICES PROHIBITED--CERTAIN DISCLOSURES REQUIRED UPON REQUEST.--

A. A pharmacy benefits manager shall not require that a pharmacy participate in one contract in order to participate in another contract.

B. A pharmacy benefits manager shall provide to a pharmacy by electronic mail, facsimile or certified mail, at least thirty calendar days prior to its execution, a contract written in plain English.

C. A contract between a pharmacy benefits manager and a pharmacy shall identify the industry standard reimbursement practice that the pharmacy benefits manager will use to determine a reimbursement amount, unless the contract is modified in writing to specify another industry standard practice.

D. The provisions of the Pharmacy Benefits Manager Regulation Act shall not be waived, voided or nullified by contract.

E. A pharmacy benefits manager shall not:

(1) cause or knowingly permit the use of any

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advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

(2) require pharmacy validation and revalidation standards inconsistent with, more stringent than or in addition to federal and state requirements for licensure and operation as a pharmacy in this state;

(3) prohibit a pharmacy or pharmacist from:

(a) mailing or delivering drugs to a patient as an ancillary service;

(b) providing a patient information regarding the patient's total cost for pharmacist services for a prescription drug; or

(c) discussing information regarding the total cost for pharmacist services for a prescription drug or from selling a more affordable alternative to the insured if a more affordable alternative is available;

(4) require or prefer a generic drug over its generic therapeutic equivalent;

(5) prohibit, restrict or limit disclosure of information by a pharmacist or pharmacy to the superintendent; [~~or~~]

(6) prohibit, restrict or limit pharmacies or pharmacists from providing to state or federal government officials general information for public policy purposes;

(7) require an insured to use a specific

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pharmacy or entity to fill a prescription drug if the pharmacy benefits manager or corporate affiliate has an ownership interest in the pharmacy or entity or if the pharmacy or entity has an ownership interest in the pharmacy benefits manager or a corporate affiliate;

(8) charge a different cost-sharing amount for prescription drugs or pharmacy services obtained at a non-affiliated pharmacy;

(9) require or incentivize the purchase of a medication in a quantity greater than prescribed;

(10) require a physician's office, hospital or infusion center to accept drugs for administration purchased by the pharmacy benefits manager or an affiliated pharmacy, whether delivered to the patient or the infusion center;

(11) require that infusion drugs be administered at home, unless the ordering physician determines that the insured's home is a safe infusion site;

(12) charge different cost-sharing for different infusion sites; however a pharmacy benefits manager may communicate with an insured regarding lower-cost sites of service; or

(13) after adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless one or more of the following applies:

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(a) the original claim was intentionally submitted fraudulently;

(b) the original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services; or

(c) the pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.

F. A pharmacy benefits manager or health [~~benefit~~] benefits plan shall not impose a fee on a pharmacy for scores or metrics or both scores and metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health [~~benefit~~] benefits plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

G. Within seven business days of a request by the superintendent or a contracted pharmacy or pharmacist, a pharmacy benefits manager or pharmacy services administrative organization shall provide as appropriate:

(1) a contract;

(2) an agreement;

(3) a claim appeal document;

(4) a disputed claim transaction document or price list; or

(5) any other information specified by law.

H. In a time and manner required by rules

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promulgated by the superintendent, a pharmacy benefits manager shall issue to the superintendent a network adequacy report describing the pharmacy benefits manager network and the pharmacy benefits manager network's accessibility to insureds statewide.

I. Pursuant to the provisions of Section 59A-4-3 NMSA 1978, the superintendent, or the superintendent's designee, may examine the books, documents, policies, procedures and records of a pharmacy benefits manager to determine compliance with applicable law. The pharmacy benefits manager shall pay the costs of the examination. At the request of a person who provides information in response to a complaint, investigation or examination, the superintendent may deem the information confidential."

SECTION 5. Section 59A-61-7 NMSA 1978 (being Laws 2017, Chapter 16, Section 2, as amended) is amended to read:

"59A-61-7. PHARMACY BENEFITS MANAGERS--PROHIBITED PHARMACY FEES.--

A. A pharmacy benefits manager shall not charge a pharmacy a fee related to the adjudication of a claim, including:

(1) the receipt and processing of a pharmacy claim;

(2) the development or management of a claim processing or adjudication network; or

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(3) participation in a claim processing or claim adjudication network.

B. A pharmacy benefits manager shall not charge a pharmacy a fee for a service unless the fee for service is itemized in the pharmacy benefits management contract.

C. A pharmacy benefits manager or health benefits plan shall not impose a fee on a pharmacy for scores or metrics. Nothing in this subsection prohibits a pharmacy benefits manager or health benefits plan from offering incentives to a pharmacy based on a score or metric; provided that the incentive is equally available to all in-network pharmacies.

D. A pharmacy benefits manager shall not conduct spread pricing in New Mexico."

SECTION 6. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] REGISTRATION OF PHARMACY SERVICES ADMINISTRATIVE ORGANIZATIONS REQUIRED.--A pharmacy services administrative organization shall register with the superintendent on a form and in a time frame and method of submission specified by the superintendent."

SECTION 7. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] PHARMACY BENEFITS REIMBURSEMENT TRANSPARENCY.--

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A. The superintendent may review and approve the compensation program of a pharmacy benefits manager with a health benefits plan to ensure that the reimbursement for pharmacist services paid to a pharmacist or pharmacy is fair and reasonable to provide an adequate pharmacy benefits manager network for a health benefits plan under the standards issued by rule. All information and data acquired during the review under this section:

(1) shall be confidential and are not subject to disclosure pursuant to the Inspection of Public Records Act; and

(2) may be shared with the office of the attorney general, the human services department, the federal trade commission and the federal centers for medicare and medicaid services.

B. A pharmacy benefits manager shall report to the superintendent on an annual basis the following information for each insurer:

(1) the itemized amount of pharmacy benefits manager revenue sources, including professional fees, administrative fees, processing fees, audits, direct and indirect renumeration fees or any other fees;

(2) the individual amount of rebates per drug distributed to the appropriate insurer or payor;

(3) the individual amount of rebates per drug

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passed on to insureds of each insurer or payor at the point of sale that reduced the insureds' applicable deductible, copayment, coinsurance or other cost-sharing amount;

(4) the individual and aggregate amount the insurer paid to the pharmacy benefits manager for pharmacy goods or services itemized for pharmacy goods and services; and

(5) the impact on premiums, insureds' cost sharing or other plan costs of the Pharmacy Benefits Manager Regulation Act.

C. A pharmacy benefits manager shall allow a plan sponsor contracting with a pharmacy benefits manager an opportunity to:

(1) audit, annually, compliance with the terms of the contract by the pharmacy benefits manager, including full disclosure of any and all rebate amounts secured, whether product-specific or generalized rebates, that were provided to the pharmacy benefits manager by a pharmaceutical manufacturer;

(2) request that the pharmacy benefits manager disclose the actual amounts paid by the pharmacy benefits manager to the pharmacy; and

(3) request information about any consideration that the pharmacy benefits manager receives from the manufacturer for dispense-as-written prescriptions once a generic or biologically similar product becomes available.

D. Failure of a pharmacy benefits manager to allow

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a plan sponsor to audit contract terms pursuant to Subsection C of this section may be enforced through a private right of action.

E. A pharmacy benefits manager shall not be paid a percentage of the cost of the drug but shall be paid a fixed fee determined in advance."

SECTION 8. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] FIDUCIARY DUTY.--An insurer that contracts with a pharmacy benefits manager to perform any activities related to the insurer's prescription drug benefits is responsible for ensuring that, under the contract, the pharmacy benefits manager acts as the insurer's agent and owes a fiduciary duty to the insurer in the pharmacy benefits manager's management of activities related to the insurer's prescription drug benefits."

SECTION 9. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] PATIENT COST SHARING.--

A. An insurer or its pharmacy benefits manager shall not require an insured to make a payment at the point of sale for a covered prescription drug in an amount greater than the least of the:

(1) applicable cost-sharing amount for the prescription drug;

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(2) amount an insured would pay for the prescription drug if the insured purchased the prescription drug without using a health benefits plan or any other source of prescription drug benefits or discounts;

(3) total amount the pharmacy will be reimbursed for the prescription drug from the pharmacy benefits manager or insurer, including the cost-sharing amount paid by an insured; or

(4) value of the rebate from the manufacturer provided to the pharmacy benefits manager for the prescribed drug.

B. If a prescription drug rebate is more than the amount needed to reduce the patient copayment to zero on a particular drug, the remainder shall be credited to the insurer or plan sponsor.

C. When calculating an insured's cost-sharing obligation for covered prescription drugs, pursuant to individual or group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act, the insurer shall credit the insured for the out-of-pocket cost for the full value of any discounts provided or payments made by third parties at the time of the prescription drug claim.

D. Any rebate amount shall be counted toward the insured's out-of-pocket prescription drug costs.

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E. If an insured or the insured's health care provider identifies a clinically appropriate, non-formulary, specialty prescription drug available at a lower cost than a drug covered on the pharmacy benefits manager's formulary, the pharmacy benefits manager shall reimburse the insured, minus applicable cost sharing, for the non-formulary drug.

F. For purposes of this section:

(1) "cost sharing" means any:

(a) copayment;

(b) coinsurance;

(c) deductible;

(d) out-of-pocket maximum amount;

(e) other financial obligation, other than a premium or share of a premium; or

(f) combination thereof; and

(2) "individual or group health coverage" means any coverage issued under the following provisions of the Insurance Code:

(a) group health coverage governed by the provisions of the Health Care Purchasing Act;

(b) individual health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 22 NMSA 1978;

(c) multiple-employer welfare

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arrangements governed by the provisions of Section 59A-15-20 NMSA 1978;

(d) group and blanket health insurance policies, health benefits plans and certificates of insurance governed by the provisions of Chapter 59A, Article 23 NMSA 1978;

(e) individual and group health maintenance organization contracts governed by the provisions of the Health Maintenance Organization Law; or

(f) individual and group nonprofit health benefits plans governed by the provisions of the Nonprofit Health Care Plan Law."

SECTION 10. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] DEVELOPING DRUG FORMULARY--COVERAGE REQUIREMENTS.--A pharmacy benefits manager that administers a pharmacy benefits program or develops a drug formulary on behalf of an insurer shall cover all medically necessary drugs."

SECTION 11. A new section of the Pharmacy Benefits Manager Regulation Act is enacted to read:

"[NEW MATERIAL] NETWORK PARTICIPATION--RESTRICTIONS.--An insurer or plan sponsor, on its own or through its contracted pharmacy benefits manager or representative of a pharmacy benefits manager, shall not restrict participation of a

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pharmacy in a pharmacy network for provider accreditation standards or certification requirements if a pharmacy meets such accreditation standards or certification requirements."

SECTION 12. TEMPORARY PROVISION--DEADLINE FOR ADOPTION OF PREFERRED DRUG LIST.--The medical assistance division of the human services department shall adopt a preferred drug list and promulgate necessary rules pursuant to this 2023 act by January 1, 2025."

SECTION 13. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to the office of superintendent of insurance for expenditure in fiscal year 2024 and subsequent fiscal years to hire staff to regulate, monitor compliance and enforce the provisions of the Pharmacy Benefits Manager Regulation Act. Any unexpended or unencumbered balance remaining at the end of a fiscal year shall not revert to the general fund.

SECTION 14. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2023.

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FISCAL IMPACT REPORT

SPONSOR Stefanics/Thomson **LAST UPDATED** **ORIGINAL DATE** 2/27/2023

SHORT TITLE Pharmacy Benefits Changes **BILL NUMBER** Senate Bill 14

ANALYST Toal

APPROPRIATION*
(dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY23	**FY24**		
	$500.0	Recurring	General

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

	FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
		$500.0	$500.0	$1,000.0	Recurring	OSI
		$16,661.0	$16,661.0	$33,322.0	Recurring	NMHCRA
		$2,800.0	$2,800.0	$5,600.0	Recurring	GSD
Total		**$19,961.0**	**$19,961.0**	**$39,922.0**		

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Relates to Senate Bill 498
Conflicts with NMRHCA Board Authority

Sources of Information

LFC Files

Responses Received From
Office of the Superintendent of Insurance (OSI)
Regulation and Licensing Department (RLD)
General Services Department (GSD)
NM Retiree Health Care Authority (NMRHCA)

No Response Received
NM Public Schools Insurance Authority

SUMMARY

Synopsis of Senate Bill 14

Senate Bill 14 amends the Pharmacy Benefit Manager Regulation Act as follows:

Section 1 of the bill revises the definitions section of the Pharmacy Benefits Manager Regulation Act, one of which is a definition of a "plan sponsor" which includes "an employer organization that offers group health plans to its employees or members," which is a broader definition than is currently found in the Insurance Code. Another provision in Section 1 is for "spread pricing," which is defined to be a "model of prescription drug pricing in which a pharmacy benefits manager charges a health benefit plan a contracted price for prescription drugs, and the contracted price for the prescription drugs differs from the amount the pharmacy benefits manager indirectly pays a pharmacist or pharmacy for pharmacist services."

Section 2 of the bill revises the application requirements for pharmacy benefit managers (PBMs) such that a PBM subcontractor to perform services must be independently licensed. The bill also gives the Superintendent the authority to require a PBM to report compliance with any portion of the Pharmacy Benefits Manager Regulation Act.

Section 3 amends the appeals process by requiring a PBM to reimburse a pharmacy in an amount that is calculated on a per-unit basis using the same generic product identifier or the generic code number. In addition, Section 3 further provides:

- That a pharmacy may file an exemption require to a maximum allowable cost denial when the average drug wholesale acquisition cost and the average sales price maximum allowable cost are unavailable to the pharmacy;
- Authorized the Superintendent to hear and resolve disputes between a PBM and pharmacy when the PBM processes have been exhausted;
- That a PBM may not reimburse a pharmacy for a prescription drug or pharmacy service in an amount less than the national average drug acquisition cost or the wholesale acquisition cost of the drug, or calculate a reimbursement amount as of any date other than the date the drug was dispenses or administered;
- That a PBM must provide a professional dispensing fee of greater than $10.49 per drug;
- That a PBM must disclose to the Superintendent the purchase prices negotiated on drugs and the prices paid to pharmacies in and out of network; and
- That a PBM shall not make or permit any reduction of payment for pharmacist services under a reconciliation process to an effective rate of reimbursement that reflects a reduction of payment.

Section 4 amends the existing provisions on PBM contracts so as to prohibit a PBM from requiring an insured to use a specific pharmacy if the PBM or its corporate affiliate has an ownership interest in the pharmacy, and also prohibits a PBM from charging a different cost-sharing amount for drugs or services at a non-affiliated pharmacy. Other provisions prohibit a PBM from requiring or incentivizing the purchase of a medication in a quantity greater than that prescribed, and prohibits denial or reduction of a claim unless the claim was intentionally submitted fraudulently, the claim was a duplicate of claim previously paid, or the goods or services were not properly rendered by the pharmacy or pharmacist.

Section 5 amends the prohibited pharmacy fees provisions so as to include imposition of a fee on a pharmacy for scores or metrics, and conducting spread pricing in New Mexico. Section 6 creates a new section to require that a pharmacy service administrative organization register with the Superintendent.

Section 7 creates a new section of the PBM Regulation Act entitled "Pharmacy Benefits Reimbursement Transparency" authorizing the Superintendent to review and approve the compensation program of a PBM to ensure that the reimbursement for pharmacist services is fair. In addition, PBMs are required to report to the Superintendent information that is based on the PBM requirements adopted by the Texas legislature in 2021. The provisions also prohibit a PBM from being paid on a percentage of the cost of a drug, and requires payment based on a fixed fee determined in advance.

Section 8 imposes a fiduciary duty on an insurer that contracts with a PBM.

Section 9 creates a new section of the act entitled "Patient Cost Sharing" which prohibits a PBM from requiring an insured to make a payment for a covered prescription drug in an amount greater than (1) the applicable cost-sharing amount for the drug, (2) the amount an insured would pay if the insured purchased the drug without using a health benefits plan, (3) the total amount the pharmacy would be reimbursed for the drug from the PBM, or (4) the value of the rebate from a drug manufacturer provided to the PBM for the drug. When calculating an insured's cost sharing obligation for covered drugs, an insurer must credit the insured for the out-of-pocket cost for the full value of any discounts provided or made by third parties at the time of the drug claim. The new provisions further provide that any rebate amount is to be counted toward the insured's out-of-pocket prescription drug costs.

Section 9 also provides that "if an insured or the insured's health care provider identifies a clinically appropriate, non-formulary, specialty prescription drug available at a lower cost than a drug covered on the PBM's formulary, the PBM must reimburse the insured, minus applicable cost sharing, for the non-formulary drug".

Section 10 requires a PBM to develop a drug formulary that covers "all medically necessary drugs."

Section 11 amends the act to include a provision that prohibits a PBM from restricting participation of a pharmacy in a pharmacy network if the pharmacy meets accreditation or certification requirements.

Section 13 of the bill appropriates $500 thousand from the general fund to the OSI in FY24 and subsequent fiscal years "to hire staff to regulate, monitor compliance and enforce the provisions of the Pharmacy Benefits Manager Regulation Act." Unexpended or unencumbered balances are not to revert to the general fund.

The effective date of the bill is July 1, 2023, although the provision relating to adoption of a preferred drug list by the Human Services Department (Section 12 of the bill) is effective January 1, 2025.

FISCAL IMPLICATIONS

Both the NMRHCA and the GSD report that the provisions of the bill would negatively impact their respective programs in a significant manner. The estimated negative cost impact to the two agencies for the next two fiscal years is in excess of $38 million. LFC is unable to estimate the cost impact to private insurers, or to PBMs. The elimination of cost sharing, the mandated use of drug manufacturer rebates, the minimum dispensing fee provision and the other provisions of the bill can reasonably be expected to increase premium rates.

SIGNIFICANT ISSUES

The provisions of SB14 will have significant operational and cost impacts on both insurers and PBMs, including public health insurers, who use PBMs and have existing contracts for such services that run through the calendar year. The plans utilize a number of measures to contain pharmacy costs, and the bill would prohibit use of a number of them.

It should be noted that for understandable reasons, the bill does not address the fundamental problem of pharmacy program costs, namely, the cost of drugs imposed by manufacturers. It also should be noted that manufacturer price or rebate coupons are required to be used are typically issued for high cost medications, which also will drive PBM costs higher.

PERFORMANCE IMPLICATIONS

The contracts of health insurers, both private and public, typically are for a calendar year. The bill has an effective date of July 1, which will present both performance and contractual issues. Consideration should be given to changing the effective date to January 1, 2024.

ADMINISTRATIVE IMPLICATIONS

If the effective date of the bill is not changed, insurance administrators will be faced with great difficulty in implementing the many changes envisioned by the bill, and in some cases, will have contractual barriers to implementation.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

SB14 is very similar to SB498.

ALTERNATIVES

The OSI has some authority to issue rules on portions of the proposed bill.

RBT/rl/ne

SENATE BILL 16

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

Elizabeth "Liz" Stefanics and Elizabeth "Liz" Thomson

AN ACT

RELATING TO EXECUTIVE REORGANIZATION; RENAMING THE HUMAN SERVICES DEPARTMENT AS THE HEALTH CARE AUTHORITY DEPARTMENT; CHANGING ITS POWERS AND DUTIES; PROVIDING FOR TRANSITION; TRANSFERRING FUNCTIONS, PERSONNEL, MONEY, APPROPRIATIONS, RECORDS, EQUIPMENT, SUPPLIES, OTHER PROPERTY, CONTRACTUAL OBLIGATIONS AND STATUTORY REFERENCES; AMENDING AND REPEALING SECTIONS OF THE NMSA 1978; RECONCILING CONFLICTING SECTIONS OF LAW IN LAWS 2019 BY REPEALING LAWS 2019, CHAPTER 211, SECTION 11.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 9-8-1 NMSA 1978 (being Laws 1977, Chapter 252, Section 1, as amended) is amended to read:

"9-8-1. SHORT TITLE.--Chapter 9, Article 8 NMSA 1978 may be cited as the [~~Human Services~~] "Health Care Authority

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Department Act"."

SECTION 2. Section 9-8-2 NMSA 1978 (being Laws 1977, Chapter 252, Section 2) is amended to read:

"9-8-2. DEFINITIONS.--As used in the [~~Human Services~~] Health Care Authority Department Act:

A. "department" means the [~~human services department created under the Human Services Department Act~~] health care authority department; and

B. "secretary" means the secretary of [~~the department~~] health care authority."

SECTION 3. Section 9-8-3 NMSA 1978 (being Laws 1977, Chapter 252, Section 3, as amended) is amended to read:

"9-8-3. PURPOSE.--The purpose of the [~~Human Services~~] Health Care Authority Department Act is to establish a single, unified department to administer laws and exercise functions relating to [~~human services and formerly administered and exercised by the administrative services unit, the state welfare and social services agencies of the health and social services department and the committee on children and youth~~] health care purchasing and regulation."

SECTION 4. Section 9-8-4 NMSA 1978 (being Laws 1977, Chapter 252, Section 4, as amended) is amended to read:

"9-8-4. DEPARTMENT ESTABLISHED.--

A. [~~There is created in the executive branch~~] The [~~human services~~] "health care authority department" is created

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in the executive branch. The department [~~shall be~~] is a cabinet department and [~~shall consist of, but not be limited to, six divisions as follows:~~

~~(1) the income support division;~~

~~(2) the administrative services division;~~

~~(3) the medical assistance division;~~

~~(4) the child support enforcement division;~~

~~(5) the behavioral health services division;~~ ~~and~~

~~(6) the information technology division~~] consists of:

(1) the office of the secretary of health care authority;

(2) the administrative services division;

(3) the information technology division;

(4) the behavioral health services division;

(5) the developmental disabilities division;

(6) the health improvement division;

(7) the medical assistance division;

(8) the state health benefits division;

(9) the child support enforcement division; and

(10) the income support division.

B. All references in the law to the behavioral health services division of the department of health or to the

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mental health division of the department of health in Sections 29-11-1 through 29-11-7 NMSA 1978 or to the department of health in Sections 43-2-1.1 through 43-2-23 NMSA 1978 shall be construed as referring to the [~~human services~~] health care authority department."

SECTION 5. Section 9-8-5 NMSA 1978 (being Laws 1977, Chapter 252, Section 6) is amended to read:

"9-8-5. SECRETARY OF [~~HUMAN SERVICES~~] HEALTH CARE AUTHORITY--APPOINTMENT.--

A. The administrative head of the [~~human services~~] health care authority department is the "secretary of [~~human services~~] health care authority", who shall be appointed by the governor with the consent of the senate and who shall serve in the executive cabinet.

B. An appointed secretary shall serve and have all of the duties, responsibilities and authority of that office during the period of time prior to final action by the senate confirming or rejecting [~~his~~] the appointed secretary's appointment."

SECTION 6. Section 9-8-6 NMSA 1978 (being Laws 1977, Chapter 252, Section 7, as amended) is amended to read:

"9-8-6. SECRETARY--DUTIES AND GENERAL POWERS.--

A. The secretary is responsible to the governor for the operation of the department. It is the secretary's duty to manage all operations of the department and to administer and

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enforce the laws with which the secretary or the department is charged.

B. To perform duties of office, the secretary has every power expressly enumerated in the laws, whether granted to the secretary or the department or any division of the department, except where authority conferred upon any division is explicitly exempted from the secretary's authority by statute. In accordance with these provisions, the secretary shall:

(1) except as otherwise provided in the [~~Human Services~~] Health Care Authority Department Act, exercise general supervisory and appointing authority over all department employees, subject to any applicable personnel laws and rules;

(2) delegate authority to subordinates as the secretary deems necessary and appropriate, clearly delineating such delegated authority and the limitations thereto;

(3) organize the department into those organizational units the secretary deems will enable it to function most efficiently, subject to any provisions of law requiring or establishing specific organizational units;

(4) within the limitations of available appropriations and applicable laws, employ and fix the compensation of those persons necessary to discharge the secretary's duties;

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(5) conduct background checks on department employees and prospective department employees that have or will have access to federal tax information; provided that:

(a) local law enforcement agency criminal history record checks shall be conducted on all employees, prospective employees, contractors, prospective contractors, subcontractors and prospective subcontractors with access to federal tax information;

(b) record checks for any identified arrests shall be conducted through local law enforcement agencies in jurisdictions where the subject has lived, worked or attended school within the last five years preceding the record check;

(c) federal bureau of investigation fingerprinting shall be conducted on all employees, prospective employees, contractors, prospective contractors, subcontractors and prospective subcontractors with access to federal tax information;

(d) for the purpose of conducting a national agency background check, the department shall submit to the department of public safety and the federal bureau of investigation a fingerprint card for each of the following personnel who have or will have access to federal tax information: 1) employees; 2) prospective employees; 3) contractors; 4) prospective contractors; 5) subcontractors; and

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6) prospective subcontractors;

(e) the department shall conduct a check for eligibility to legally work as a citizen or legal resident of the United States on all employees, prospective employees, contractors, prospective contractors, subcontractors and prospective subcontractors with access to federal tax information. The department shall complete a citizenship or residency check for each new employee and any employee with expiring employment eligibility and shall document and monitor the employee's citizenship or residency status for continued compliance;

(f) criminal history records obtained by the department pursuant to the provisions of this paragraph and the information contained in those records are confidential, shall not be used for any purpose other than conducting background checks for the purpose of determining eligibility for employment and shall not be released or disclosed to any other person or agency except pursuant to a court order or with the written consent of the person who is the subject of the records;

(g) a person who releases or discloses criminal history records or information contained in those records in violation of the provisions of this paragraph is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

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(h) the secretary shall adopt and promulgate rules to establish procedures to provide for background checks; provided that background checks shall not be evaluated for any purpose other than a person's department-related activities, and criteria according to which background checks are evaluated, for all present and prospective personnel identified in the provisions of this paragraph;

(i) contractors, prospective contractors, subcontractors and prospective subcontractors shall bear any costs associated with ordering or conducting background checks pursuant to this paragraph; and

(j) a department employee or prospective department employee who is denied employment or whose employment is terminated based on information obtained in a background check shall be entitled to review the information obtained pursuant to this paragraph and to appeal the decision;

(6) take administrative action by issuing orders and instructions, not inconsistent with the law, to assure implementation of and compliance with the provisions of law for whose administration or execution the secretary is responsible and to enforce those orders and instructions by appropriate administrative action in the courts;

(7) conduct research and studies that will improve the operations of the department and the provision of services to the citizens of the state;

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(8) provide courses of instruction and practical training for employees of the department and other persons involved in the administration of programs with the objective of improving the operations and efficiency of administration;

(9) prepare an annual budget of the department;

(10) provide cooperation, at the request of heads of administratively attached agencies, in order to:

(a) minimize or eliminate duplication of services and jurisdictional conflicts;

(b) coordinate activities and resolve problems of mutual concern; and

(c) resolve by agreement the manner and extent to which the department shall provide budgeting, recordkeeping and related clerical assistance to administratively attached agencies; and

(11) appoint, with the governor's consent, a "director" for each division. These appointed positions are exempt from the provisions of the Personnel Act. Persons appointed to these positions shall serve at the pleasure of the secretary, except as provided in Section 9-8-9 NMSA 1978.

[~~(12) give bond in the penal sum of twenty-five thousand dollars ($25,000) and require directors to each give bond in the penal sum of ten thousand dollars ($10,000)~~

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~~conditioned upon the faithful performance of duties as provided in the Surety Bond Act. The department shall pay the costs of these bonds; and~~

~~(13) require performance bonds of such department employees and officers as the secretary deems necessary as provided in the Surety Bond Act. The department shall pay the costs of these bonds.~~]

C. The secretary may apply for and receive, with the governor's approval, in the name of the department, any public or private funds, including United States government funds, available to the department to carry out its programs, duties or services.

D. Where functions of departments overlap or a function assigned to one department could better be performed by another department, the secretary may recommend appropriate legislation to the next session of the legislature for its approval.

E. The secretary may make and adopt such reasonable procedural rules as may be necessary to carry out the duties of the department and its divisions. No rule promulgated by the director of any division in carrying out the functions and duties of the division shall be effective until approved by the secretary unless otherwise provided by statute. Unless otherwise provided by statute, no rule affecting any person or agency outside the department shall be adopted, amended or

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repealed without a public hearing on the proposed action before the secretary or a hearing officer designated by the secretary. The public hearing shall be held in Santa Fe unless otherwise permitted by statute. Notice of the subject matter of the rule, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed rule or proposed amendment or repeal of an existing rule may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general circulation and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

F. In the event the secretary anticipates that adoption, amendment or repeal of a rule will be required by a cancellation, reduction or suspension of federal funds or order by a court of competent jurisdiction:

(1) if the secretary is notified by appropriate federal authorities at least sixty days prior to the effective date of such cancellation, reduction or termination of federal funds, the department is required to promulgate rules through the public hearing process to be effective on the date mandated by the appropriate federal authority; or

(2) if the secretary is notified by

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appropriate federal authorities or court less than sixty days prior to the effective date of such cancellation, reduction or suspension of federal funds or court order, the department is authorized without a public hearing to promulgate interim rules effective for a period not to exceed ninety days. Interim rules shall not be promulgated without first providing a written notice twenty days in advance to providers of medical or behavioral health services and beneficiaries of department programs. At the time of the promulgation of the interim rules, the department shall give notice of the public hearing on the final rules in accordance with Subsection E of this section.

G. If the secretary certifies to the secretary of finance and administration and gives contemporaneous notice of such certification through the human services register that the department has insufficient state funds to operate any of the programs it administers and that reductions in services or benefit levels are necessary, the secretary may engage in interim rulemaking. Notwithstanding any provision to the contrary in the State Rules Act, interim rulemaking shall be conducted pursuant to Subsection E of this section, except:

(1) the period of notice of public hearing shall be fifteen days;

(2) the department shall also send individual notices of the interim rulemaking and of the public hearing to

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affected providers and beneficiaries;

(3) rules promulgated pursuant to the provisions of this subsection shall be in effect not less than five days after the public hearing;

(4) rules promulgated pursuant to the provisions of this subsection shall not be in effect for more than ninety days; and

(5) if final rules are necessary to replace the interim rules, the department shall give notice of intent to promulgate final rules at the time of notice herein. The final rules shall be promulgated not more than forty-five days after the public hearing and filed in accordance with the State Rules Act.

H. At the time of the promulgation of the interim rules, the department shall give notice of the public hearing on the final rules in accordance with Subsection E of this section.

I. The secretary shall ensure that any behavioral health services, including mental health and substance abuse services, provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978.

J. All rules shall be filed in accordance with the State Rules Act."

SECTION 7. Section 9-8-7 NMSA 1978 (being Laws 1977, Chapter 252, Section 8) is amended to read:

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"9-8-7. ORGANIZATIONAL UNITS OF DEPARTMENT--POWERS AND DUTIES SPECIFIED BY LAW--ACCESS TO INFORMATION.--Those organizational units of the department and the officers of those units specified by law shall have all of the powers and duties enumerated in the specific laws involved. However, the carrying out of those powers and duties shall be subject to the direction and supervision of the secretary, and [~~he~~] the secretary shall retain the final decision-making authority and responsibility for the administration of any such laws as provided in Subsection B of Section [~~7 of the Human Services Department Act~~] 9-8-6 NMSA 1978. The department shall have access to all records, data and information of other state departments, agencies and institutions, including its own organizational units, not specifically held confidential by law."

SECTION 8. Section 9-8-7.1 NMSA 1978 (being Laws 2007, Chapter 325, Section 4, as amended by Laws 2019, Chapter 211, Section 1 and by Laws 2019, Chapter 222, Section 1) is amended to read:

"9-8-7.1. BEHAVIORAL HEALTH SERVICES DIVISION--POWERS AND DUTIES OF THE [~~HUMAN SERVICES~~] DEPARTMENT.--Subject to appropriation, the department shall:

A. contract for behavioral health treatment and support services, including mental health, alcoholism and other substance abuse services;

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B. establish standards for the delivery of behavioral health services, including quality management and improvement, performance measures, accessibility and availability of services, utilization management, credentialing and recredentialing, rights and responsibilities of providers, preventive behavioral health services, clinical treatment and evaluation and the documentation and confidentiality of client records;

C. ensure that all behavioral health services, including mental health and substance abuse services, that are provided, contracted for or approved are in compliance with the requirements of Section 9-7-6.4 NMSA 1978;

D. assume responsibility for and implement adult mental health and substance abuse services in the state in coordination with the children, youth and families department;

E. create, implement and continually evaluate the effectiveness of a framework for targeted, individualized interventions for [~~individuals~~] persons who are incarcerated in a county or municipal correctional facility and adult and juvenile offenders who have behavioral health diagnoses, which framework shall address those persons' behavioral health needs while they are incarcerated and connect them to resources and services immediately upon release;

F. establish criteria for determining individual eligibility for behavioral health services; and

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G. maintain a management information system in accordance with standards for reporting clinical and fiscal information."

SECTION 9. Section 9-8-7.2 NMSA 1978 (being Laws 2013, Chapter 54, Section 9) is amended to read:

"9-8-7.2. COOPERATION WITH THE NEW MEXICO HEALTH INSURANCE EXCHANGE.--The medical assistance division of the [~~human services~~] department shall cooperate with the New Mexico health insurance exchange to share information and facilitate transitions in enrollment between the exchange and medicaid."

SECTION 10. Section 9-8-7.3 NMSA 1978 (being Laws 2019, Chapter 222, Section 2) is amended to read:

"9-8-7.3. INCARCERATED [~~INDIVIDUALS~~] PERSONS--BEHAVIORAL HEALTH SERVICES--COUNTY FUNDING PROGRAM.--To carry out the provisions of Subsection E of Section 9-8-7.1 NMSA 1978 and to provide behavioral health services to [~~individuals~~] persons who are incarcerated in a county correctional facility:

A. the secretary shall adopt and promulgate rules:

(1) pursuant to which a county may apply for and be awarded funding through the department; and

(2) to establish priorities and guidelines for the award of funding to counties; and

B. the department shall distribute funds, as funding permits, to the county health care assistance funds of those counties:

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(1) that apply for behavioral health services funding in accordance with department rules; and

(2) whose proposed utilization of funding pursuant to this section meets the priorities and guidelines for the awarding of behavioral health services funding established in department rules."

SECTION 11. Section 9-8-7.4 NMSA 1978 (being Laws 2019, Chapter 211, Section 2) is amended to read:

"9-8-7.4. INCARCERATED [~~INDIVIDUALS~~] PERSONS--BEHAVIORAL HEALTH SERVICES--COUNTY FUNDING PROGRAM.--To carry out the provisions of Subsection E of Section 9-8-7.1 NMSA 1978 and to provide behavioral health services to [~~individuals~~] persons who are incarcerated in a county correctional facility:

A. the secretary shall adopt and promulgate rules:

(1) pursuant to which a county may apply for and be awarded funding through the department; and

(2) to establish priorities and guidelines for the award of funding to counties; and

B. the department shall distribute funds, as funding permits, to the county health care assistance funds of those counties:

(1) that apply for behavioral health services funding in accordance with department rules; and

(2) that have proposed utilization of funding pursuant to this section that meets the priorities and

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guidelines for the awarding of behavioral health services funding established in department rules."

SECTION 12. Section 9-8-8 NMSA 1978 (being Laws 1977, Chapter 252, Section 9, as amended by Laws 2004, Chapter 18, Section 16 and by Laws 2004, Chapter 23, Section 12 and also by Laws 2004, Chapter 24, Section 16) is amended to read:

"9-8-8. ADMINISTRATIVELY ATTACHED AGENCIES.--The following agencies are administratively attached to the department:

A. the commission on the status of women [~~is administratively attached to the human services department in accordance with the Executive Reorganization Act~~];

B. the group benefits committee; and

C. the New Mexico health policy commission."

SECTION 13. Section 9-8-10 NMSA 1978 (being Laws 1977, Chapter 252, Section 11, as amended) is amended to read:

"9-8-10. BUREAUS--CHIEFS.--The secretary shall establish within each division such bureaus as [~~he~~] the secretary deems necessary to carry out the provisions of the [~~Human Services~~] Health Care Authority Department Act. [~~He~~] The secretary shall employ a chief to be administrative head of any such bureau. The chief and all subsidiary employees of the department shall be covered by the Personnel Act unless otherwise provided by law."

SECTION 14. Section 9-8-11 NMSA 1978 (being Laws 1977,

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Chapter 252, Section 12, as amended) is amended to read:

"9-8-11. ADVISORY COMMITTEES.--

A. The governor shall appoint advisory committees to the department's income support division [~~and the social services division~~]. Creation of the advisory committees shall be in accordance with the provisions of the Executive Reorganization Act. If the existence of a committee, representational membership requirements or other matters are required or specified under any federal law, regulation, rule or order as a condition of receiving federal funding for a particular [~~human services~~] program administered by the department, the governor shall comply with [~~such~~] those requirements in the creation of the advisory committee.

B. All members of the advisory committees appointed under the authority of this section shall receive as their sole remuneration for service as a member those amounts authorized under the Per Diem and Mileage Act."

SECTION 15. Section 9-8-12 NMSA 1978 (being Laws 1977, Chapter 252, Section 13) is amended to read:

"9-8-12. COOPERATION WITH THE FEDERAL GOVERNMENT--AUTHORITY OF SECRETARY--SINGLE STATE AGENCY STATUS.--

A. The department is authorized to cooperate with the federal government in the administration of health care and human services programs in which financial or other participation by the federal government is authorized or

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mandated under federal laws, regulations, rules or orders. The secretary may enter into agreements with agencies of the federal government to implement these health care or human services programs subject to availability of appropriated state funds and any provisions of state laws applicable to such agreements or participation by the state.

B. The governor or the secretary may by appropriate order designate the department or any organizational unit of the department as the single state agency for the administration of any health care or human services program when such designation is a condition of federal financial or other participation in the program under applicable federal law, regulation, rule or order. Whether or not a federal condition exists, the governor may designate the department or any organizational unit of the department as the single state agency for the administration of any health care or human services program. No designation of a single state agency under the authority granted in this section shall be made in contravention of state law."

SECTION 16. TEMPORARY PROVISION--TRANSFERS AND TRANSITION.--

A. The governor may issue an executive order that further delineates the organizational structure, power and duties of the health care authority department and moves divisions and programs to or from other departments to

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accomplish the reorganizational goals of this act. The governor shall report the reorganizational changes and recommend statutory changes to the legislative health and human services committee and the legislative finance committee by November 1, 2023 and provide a final reorganization report to the legislature by January 1, 2024.

B. On July 1, 2023, statutory references to the human services department shall be deemed to be references to the health care authority department, and contractual obligations of the human services department shall be binding on the health care authority department. Rules of the human services department shall be the rules of the health care authority department until amended or repealed. As functions of government are transferred to the health care authority department as specified in Section 9-8-4 NMSA 1978, statutory references shall be deemed to be references to the health care authority department, contractual obligations shall be binding on the department and existing pertinent rules shall be the rules of the department until amended or repealed.

C. The department of finance and administration, the secretary of health care authority, the secretary of health, the secretary of general services, members of the governor's staff and other persons assigned by the governor shall develop a transition plan that includes:

(1) what units of the executive department

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shall be transferred to or from the health care authority department and working and final organizational charts for all affected units of the executive departments;

(2) how and when functions, personnel, money, appropriations, equipment, supplies and other property of the human services department, the department of health, the general services department and other units of the executive department shall be transferred to or from the health care authority department; and

(3) proposed statutory changes, including changes in Chapters 9, 10 and 24 NMSA 1978 and the creation of a new chapter of the NMSA 1978 to include sections of Chapters 9 and 24 NMSA 1978 and other provisions of law pertaining to health care purchasing and regulation.

SECTION 17. REPEAL.--

A. Sections 9-8-13 and 9-8-14 NMSA 1978 (being Laws 1977, Chapter 252, Section 15 and Laws 1987, Chapter 31, Section 4, as amended) are repealed.

B. Laws 2019, Chapter 211, Section 1 is repealed.

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SENATE BILL 453

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

Martin Hickey

AN ACT

RELATING TO PUBLICLY FUNDED HEALTH CARE PROGRAMS; AMENDING THE HEALTH CARE PURCHASING ACT TO UPDATE PUBLICLY FUNDED HEALTH CARE AGENCY OBLIGATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 13-7-4 NMSA 1978 (being Laws 1997, Chapter 74, Section 4) is amended to read:

"13-7-4. MANDATORY CONSOLIDATED PURCHASING.--

A. The publicly funded health care agencies shall enter into a cooperative consolidated purchasing effort to provide plans of health care benefits for the benefit of eligible participants of the respective agencies. The request for [~~proposal~~] proposals shall set forth one or more plans of health care benefits and shall include accommodation of fully funded arrangements as well as varying degrees of self-funded

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pool options.

B. A consolidated purchasing request for proposals for all health care benefits by the publicly funded health care agencies shall be issued on or before July 1, 1999 and any contracts for health care benefits renewed or issued on or after July 1, 2000 shall be the result of consolidated purchasing.

C. All requests for proposals issued as part of the consolidated purchasing shall include at least one distinct service area consisting of the Albuquerque metropolitan area. Proposals on a distinct service area shall be evaluated separately.

D. All requests for proposals issued as part of the consolidated purchasing for commercial plans shall include requests for self-insured and fully insured proposals for health care benefits.

E. Any contract for the consolidated purchasing of health care benefits entered into on or after July 1, 2023 shall be for a duration of no longer than one calendar year."

SECTION 2. Section 13-7-7 NMSA 1978 (being Laws 2001, Chapter 351, Section 3, as amended) is amended to read:

"13-7-7. CONSOLIDATED ADMINISTRATIVE FUNCTIONS--BENEFIT.--

A. The publicly funded health care agencies, political subdivisions and other persons participating in the

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consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into a joint powers agreement pursuant to the Joint Powers Agreements Act with the publicly funded health care agencies and political subdivisions to determine assessments or provisions of resources to consolidate, standardize and administer the consolidated purchasing single process and subsequent activities pursuant to the Health Care Purchasing Act. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into contracts with nonpublic persons to provide the service of determining assessments or provision of resources for consolidation, standardization and administrative activities.

B. Each agency shall retain its responsibility to determine policy direction of the benefit plans, plan development, training and coordination with respect to participants and its benefits staff, as well as to respond to benefits eligibility inquiries and establish and enforce eligibility rules.

C. Notwithstanding Subsection B of this section, publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act shall provide coverage for children, from birth through three years

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of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract.

D. Each publicly funded health care agency shall provide an annual open enrollment period for all plan participants. During the open enrollment period, each agency shall provide comparative information to each plan participant about coverage, program features, benefits and costs. The comparative information shall be:

(1) provided to plan participants in writing;

(2) made available on the internet; and

(3) made available at an in-person open enrollment event that occurs at least once each open enrollment period on the premises of each entity that participates in consolidated purchasing pursuant to the Health Care Purchasing Act.

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E. Each publicly funded health care agency shall conduct claims recovery audits that continually audit medical and pharmaceutical claims to ensure that claims are paid for properly and accurately."

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SENATE BILL 484

56TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2023

INTRODUCED BY

Martin Hickey

AN ACT

RELATING TO HEALTH CARE; AMENDING THE HEALTH CARE PURCHASING ACT TO UPDATE PUBLICLY FUNDED HEALTH CARE AGENCY OBLIGATIONS; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 13-7-5 NMSA 1978 (being Laws 2001, Chapter 351, Section 1) is amended to read:

"13-7-5. CONSOLIDATED PURCHASING FOR OTHER PERSONS.--

A. Counties, municipalities, state educational institutions and other political subdivisions that wish to use the consolidated purchasing single process for the procurement of health care benefits shall create or enter into an existing association, cooperative or other mutual alliance to create larger pools of eligible participants.

B. Counties, municipalities, state educational

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institutions and other political subdivisions that wish to use the consolidated purchasing single process shall, through their respective association, cooperative or mutual alliance, participate in the subsequent consolidated purchasing single process with the publicly funded health care agencies.

C. Any state higher education institution that chooses not to participate in the consolidated purchasing single process shall provide a report to the legislative finance committee that explains the institution's decision."

SECTION 2. Section 13-7-7 NMSA 1978 (being Laws 2001, Chapter 351, Section 3, as amended) is amended to read:

"13-7-7. CONSOLIDATED ADMINISTRATIVE FUNCTIONS--BENEFIT.--

A. The publicly funded health care agencies [~~political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may~~] shall enter into a joint powers agreement pursuant to the Joint Powers Agreements Act [~~with the publicly funded health care agencies and political subdivisions~~] to determine assessments or provisions of resources to consolidate, standardize and administer the consolidated purchasing single process and subsequent activities pursuant to the Health Care Purchasing Act. Political subdivisions and other persons participating in the consolidated purchasing single process may enter into the joint

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powers agreement created by the publicly funded health care agencies. The publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act may enter into contracts with nonpublic persons to provide the service of determining assessments or provision of resources for consolidation, standardization and administrative activities.

B. The publicly funded health care agencies shall agree to and submit a proposed joint powers agreement to the department of finance and administration and the legislative finance committee no later than July 1, 2023. The legislative finance committee and department of finance and administration may only approve the joint powers agreement if the agreement provides for:

(1) the development of at least one common, uniform benefit plan design to be offered to the beneficiaries of each of the publicly funded health care agencies; and

(2) increased transparency of consolidated purchasing by:

(a) reporting all claims, utilization and payment data to the all-payer claims database; and

(b) annual reporting to the legislative finance committee on topics that include the cost and quality of benefits provided by each medical benefits plan.

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[~~B.~~] C. Each agency shall retain its responsibility to determine policy direction of the benefit plans, plan development, training and coordination with respect to participants and its benefits staff, as well as to respond to benefits eligibility inquiries and establish and enforce eligibility rules.

[~~C.~~] D. Notwithstanding Subsection [~~B~~] C of this section, publicly funded health care agencies, political subdivisions and other persons participating in the consolidated purchasing single process pursuant to the Health Care Purchasing Act shall provide coverage for children, from birth through three years of age, for or under the family, infant, toddler program administered by the early childhood education and care department, provided eligibility criteria are met, for a maximum benefit of three thousand five hundred dollars ($3,500) annually for medically necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel who are working in early intervention programs approved by the early childhood education and care department. No payment under this subsection shall be applied against any maximum lifetime or annual limits specified in the policy, health benefits plan or contract."

SECTION 3. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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New Mexico Retiree Health Care Authority (CP)
Change in Market Value
For the Month of Jan 2023
(Report as of February 15, 2023)

Investment Name	Prior Ending Market Value	Contributions	Distributions	Fees	Income	Gains - Realized & Unrealized	Market Value
Core Bonds Pool	181,116,702.54	-	-	-	537,549.86	5,197,471.52	186,851,723.92
Credit & Structured Finance	167,797,205.03	-	-	-	232,336.57	379,586.72	168,409,128.32
NM Retiree Health Care Authority Cash Account	-	-	-	-	-	-	-
Non-US Developed Markets Index Pool	139,207,019.34	-	-	-	104,827.14	10,761,228.27	150,073,074.75
Non-US Emerging Markets Active Pool	85,039,036.63	-	-	-	41,766.64	6,954,147.43	92,034,950.70
Private Equity Pool	171,909,489.24	-	-	-	10,014.13	352,071.26	172,271,574.63
Real Estate Pool	134,932,660.19	-	-	-	301,227.75	(164,170.15)	135,069,717.79
Real Return Pool	55,898,545.65	-	-	-	176,170.10	120,233.08	56,194,948.83
US Large Cap Index Pool	168,669,998.55	-	-	-	172,382.72	11,203,734.73	180,046,116.00
US SMID Cap Alternative Weighted Index Pool	23,190,853.40	-	-	-	20,913.62	2,180,166.40	25,391,933.42
Sub - Total New Mexico Retiree Health Care	1,127,761,510.57	-	-	-	1,597,188.53	36,984,469.26	1,166,343,168.36
Total New Mexico Retiree Health Care A	**1,127,761,510.57**	**-**	**-**	**-**	**1,597,188.53**	**36,984,469.26**	**1,166,343,168.36**

FY23 New Contract
Web Portal Application Services – Action Item*

Background:
The NMRHCA web portal platform is being built for members to be able to complete general enrollments and submit change forms utilizing the web-based online tool. This will give retirees the ability to upload their scanned documents, reviewing benefits, and requesting changes to personal information. The web portal will also allow NMRHCA to do data validation to ensure that the forms are filled out correctly to help to reduce errors, reduce phone calls, and eliminate the manual process of scanning documents. This Portal was designed and developed by current website host and vendor – Real Time Solutions. This contract would be under the statewide price agreement 90-00000-19-00065 BX.

Issue: The Web portal functionality is continuing to evolve due to changes in process, new requirements (CMS – Race/Ethnicity), errors/bugs found and eliminated, and some previous undetected design flaws. Additional work and funds are needed to pursue and finish a stable, secure, complete, and steady version 1 environment.

Overview: The Agency is requiring additional funding to have the work listed below done by the Web portal developer from Real Time Solutions.

Scope of Work (summary)

a. Replace current summary PDF form in portal with standardize RHCA version.
b. Add digital signatures to each signing location (nine total).
c. New Change Request checkbox for life changing event which changes logic and next steps of procedure.
d. Correct disability handling portion procedures and data displayed.
e. Add new subsection to handle additional, purchased years of service – via Airtime and military service time.
f. Add ability to upload individual documents by retiree separately, after application submittal.
g. Application submission tracking and change(s) auditing.

The cost estimate for these services is $13,307.13 (130 hours x $95 per hour + $957.13 tax)

Action Item Request: NMRHCA Staff respectfully requests permission to enter into a new contract with Real Time Solutions to provide the specified scope of work.

FY23 New Contract (Small Purchase) – Action Item*

Internal Audit Services

Background:
NMRHCA continues to look at opportunities to drive better efficiencies within the agency and have identified services that can improve operations by evaluating current process and procedures in place. This will ensure compliance, operating efficiency, and safeguard information and assets this agency is entrusted with. This is a common practice that other agencies conduct.

Scope of Work:
Contractor shall provide NMRHCA independent, objective internal audit services designed to add value to improve the agency's operations. These services will assist the agency in accomplishing its objectives by contributing to the evaluation and improvement of the effectiveness of risk management, internal control, and governance processes.

- Perform independent assessments on the systems of risk management, internal controls, and operating efficiency, guided by professional standards
- Support the agency's efforts to achieve its objectives through independent internal auditing services.

The objective of these services are to provide independent assurance to the NMRHCA Board of Directors, executive director, management, and members, retirees, beneficiaries, and the public that NMRHCA assets are safeguarded with appropriate internal controls, that operating efficiency is enhanced, that reporting by managers, staff, agency, and consultants is accurate, well designed, appropriately informative and under adequate controls, and compliance is maintained with prescribed laws, and Board and management policies. These objectives include independent assessment of NMRHCA's risk awareness and management, reliability and integrity of the organization's data and achievement of NMRHCA's goals and objectives.

The contractor should submit a quote for work with a proposed timeline to finish work prior to end of fiscal year 6/30/2023. The work will be specific to the items listed below with an estimate of hours to be about 180.

Review of Accounting and Finance - Policies and Procedures

- Perform interviews with Finance personnel to gain an understanding of current processes in place.
- Evaluate policies and procedures to provide an analysis on where gaps may exist in documented processes as well as where internal controls and best practices can be implemented/ documented in the P&P's.
- Evaluate the financial close and reporting process to ensure proper internal controls and best practices are in place.
- Analyze roles and responsibilities to ensure proper segregation of duties and backups of key processes are in place.

Information Technology – Policies and Procedures

- Perform interviews with IT personnel to gain an understanding of current processes in place.
- Assist the IT team in prioritizing a list of policies and procedures that need be completed by IT and others, including timelines for completion.
- Contractor will assist with meeting facilitation to ensure process documents meet the needs of both agency locations.
- NMRHCA drafted documents will be reviewed for gaps and contractor will provide feedback as well as monitor project status and report on the timelines to management.

Action Item Request: NMRHCA staff respectfully requests permission to contract with an audit firm to provide internal audit services for the scope of work referenced, not to exceed $40,000 to improve internal process and operations within the agency.

FY23 Program Support Contractual Services
Year to Date

Includes proposed new small contracts highlighted below in blue.

	FY23 Approved Operating Budget		**$674,900**			
			Proposed			
			Contract		**Contract**	
	Vendor		**Amount**		**Term**	**Type**
1	Segal		$345,000		July 1, 2019 - June 30, 2023	Term/Comp
2	Judith Beatty		$7,000		July 1, 2022 - June 30, 2023	DPO
3	Moss Adams		$70,390		July 1, 2020 - June 30, 2023	Term/Comp
4	Rodey Legal Services		$40,000		July 1, 2022 - June 30, 2023	Small
5	RESPEC		$55,017		July 1, 2022 - June 30, 2023	Price Agreement
6	PERA MOU - HR Services		$16,037		July 1, 2022 - June 30, 2023	MOU
7	Work Quest - Shredding Services		$4,095		July 1, 2022 - June 30, 2023	Small
8	Real Time Web Hosting		$1,317		July 1, 2022 - June 30, 2023	Small
9	NMPSIA - Consultant for Life RFP		$8,500		July 1, 2022 - June 30, 2023	MOU
10	Albuquerque Computers		$441		July 1, 2022 - June 30, 2023	DPO
11	Wilshire - Asset Allocation Review		$35,000		July 1, 2022 - June 30, 2023	Small
12	SHI International		$34,847		July 1, 2022 - June 30, 2023	Small
13	Real Time Web-based Portal		$13,308		July 1, 2022 - June 30, 2023	New Small
14	TBD - Internal Audit Services		$40,000		July 1, 2022 - June 30, 2023	New Small
	Total		**$670,952**			
	Unencumbered Balance		**$3,948**		**Availble for mid/end-year adjustments**	

Financial Audit RFP - Action Item*

Background: The New Mexico Retiree Health Care Authority is authorized to enter 1-year agreements for up to 3 years prior to initiating the procurement process for Independent Public Accountant (IPA) services. The financial audits for FY22 represents the limit of NMRHCA's agreement with Moss Adams for audit services as this will complete the 3rd year of the contract. Additionally, Audit Rule and State Procurement Code require NMRHCA to seek approval from the Office of the State Auditor (OSA) prior to beginning the process of procuring IPA services. As such, in anticipation of the State Auditor releasing and approving directions and guidelines regarding the 2023 Audit Rule and procuring parameters, NMRHCA staff is seeking Board approval to initiate the IPA procurement process.

Action Item: NMRHCA staff respectfully requests approval to seek the OSA's authorization to issue a RFP for professional financial audit services.

Plan Comparison - NM Retiree Health Care Authority, NM Public School Insurance Authority, Albuquerque Public Schools, and State of New Mexico RMD as of 1/1/2023

Medical Plans:

Plan Premiums for individual member per month with employer subsidy of 64%	**Premier PPO -** $322.96 (BCBS Tier 1 and Both plans Tier 2)	**Value Plan HMO -** $252.28	**SONM PPO -** $224.95 or $222.70	**SONM HMO -** $193.42 or $191.49	**NMPSIA High Option -** $309.74, $295.75, $250.47	**NMPSIA EPO -** $278.76	**NMPSIA Low Option -** $214.75, $206.01, $173.69	**APS PPO BCBS and Cigna -** $207.23 or $213.44/ $276.32 or $284.60 Food Services	**APS EPO Presbyterian -** $217.58 or $290.11 Food Services
Annual Deductible	$500 to $800/Individual	$1,500/Individual	$500 to $750/Individual	$350/ $425/ $500/Individual	$750/Individual	$500/Individual	$2,000/Individual	$1,000/Individual	$500/Individual
Annual Out-of-Pocket Limit	$3,750 to 4,500/Individual	$5,500/Individual	$4,000 or $5,000/Individual	$3,750/ $4,000/$4,250/ $5,000/ Individual	$4,100/Individual	$3,250/Individual	$4,100/Individual	$5,000/Individual	$4,000/Individual
Office Services	Primary - $20 or $30 Specialist - $35 to $45	Primary -$35 Specialist - $55	Primary -$40-$50 Specialist - $60-$70	Primary -$25, $35, $40 Specialist - $45, $50, $60	Primary -$25 Specialist - $50	Primary -$25 Specialist - $35	Primary -$30 Specialist - $60	Primary -$30 Specialist - $60	Primary -$20 Specialist - $50
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Related testing (includes routine Pap test, mammograms, colonoscopy, physicals, etc.) & immunization (deductible waived)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Lab, X-Ray, and Pathology	Plan pays 100%	Plan pays 100%	30%-40%	$20, $100, 25%	$30 freestanding lab/ radiology or actual allowed or $60 hospital outpatient or actual allowed, (which ever is less per day)	$25 freestanding lab/ radiology or actual allowed or $50 hospital outpatient or actual allowed, (which ever is less per day)	$35 freestanding lab/ radiology or actual allowed or $70 hospital outpatient or actual allowed, (which ever is less per day)	$30	$20
Emergency Room	$250	$350	$325	20%, $300	$450 copay	$150 copay plus 20% after deductible	$450 copay after deductable	$450	$350
Urgent Care Facility	$45	$55	$65-$75	$100, $60	$50	$45	$60	$75	$50
Ambulance Services	25%	30%	20%, 30%	20% or $30 Ground/$100 Air	$50 copay	$25	25%	20%	20%
High-Tech Radiology (MRI, PET & CT)	10%, 25% or $100 office/ freestanding radiology	30% or $125 office/ freestanding radiology	25% to max $300 per test or $300 copay per test per day	$250 per test per day; 25% up to max of $250 per test	$600 copay or 20% which ever is less per day	$500 copay or 20% which ever is less per day	$700 copay or 25% which ever is less per day	$120 or $175 copay per day freestanding facility, 20% outpatient hospital	$120 copay per day freestanding facility, 20% outpatient hospital
Rehabilitation Inpatient or Outpatient (Occupational, Physical, and Speech)	10% or 25% / $20 or $30 - Physical therapy outpatient alternative to surgery 4 copay max	30% / $35 - Physical therapy outpatient alternative to surgery 4 copay max	$1,250 - $1,750 Inpatient/ $40-$50 Outpatient	20% or $700 Inpatient/$25, $35 or $40 Outpatient	20% Inpatient/$25 copay up to $250; thereafter no charge for remainding calendar year	$500 copay plus 20% Inpatient/ $25 up to $250 then no charge rest of year Outpatient	25% Inpatient/ $30 Outpatient	20% Inpatient, $30 maximum $480 per CY and 60 visit max per condition	20% Inpatient, $20 maximum $320 per CY and 60 visit max per condition
Alternative (chiropractic, acupuncture, etc.)	10% or 25%	30%	$60-$70, max 25 combined visits a year	$50 or $55, max 25 combined visits a year	$50, combined max 30 visits	$35, combined max 30 visits	25%, combined max 30 visits	$30, max 25 or 20 visits a calendar year	$20, max 25 visits a calendar year
Hospitalization - Inpatient	10% or 25%	30%	$1,250-$1750 per admission	20% or $700 per admission	20% coinsurance after deductible	$500 facility copay plus admission 20%	25%	20%	20%
Surgery - Outpatient	10% or 25%	30%	25%/$500 per visit and 35%/$700 per visit and $500 copay/visit, plus 25% coinsurance	$500 or $250 copay plus 25%	20% coinsurance after deductible	$150 copay plus 20%	25%	20%	20%
Majority of Other Covered Services	10% or 25%	30%	Vary	Vary	Vary	Vary	25%	20%	20%

Plan Comparison - NM Retiree Health Care Authority, NM Public School Insurance Authority, Albuquerque Public Schools, and State of New Mexico RMD as of 1/1/2023

Prescription Plans:

Copay (Retail)	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*
Generic	$5	$15	$5	$15	$6		$6		$10		$10		$10		20%	$10	20%	$10
Brand	$30	$60	$30	$60	$35	$95	$35	$95	$30	$60	$30	$60	$30	$60	$35	$75	$35	$75
Brand Non-Formulary	$50	$125	$50	$125	$60	$130	$60	$130	70%		70%		70%		$70	$150	$70	$150
Specialty					$60 generic, $85 preferred brand, $125 non-preferred brand		$60 generic, $85 preferred brand, $125 non-preferred brand											
Up to 30 or 34 day supply					**$50 deductible applies to formulary and non-formulary only		**$50 deductible applies to formulary and non-formulary only											
Copay (Mail Order)	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*	*Minimum*	*Maximum*
Generic	$12	$35	$12	$35	$17		$17		$22		$22		$22		$20		$20	
Preferred Brand	$60	$120	$60	$120	$120		$120		$60		$60		$60		$90		$90	
Non-Formulary	$100	$250	$100	$250	$155		$155		70%		70%		70%		$180		$180	
Specialty					$60 generic, $85 preferred brand, $125 non-preferred brand		$60 generic, $85 preferred brand, $125 non-preferred brand		$55 generic, $80 preferred brand, $130 non-preferred (30 day)		$55 generic, $80 preferred brand, $130 non-preferred (30 day)		$55 generic, $80 preferred brand, $130 non-preferred (30 day)		$70, $100, $150 based on tier		$70, $100, $150 based on tier	