HOUSE BILL 136

57TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2026

INTRODUCED BY

Kathleen Cates and Elizabeth "Liz" Thomson

AN ACT

RELATING TO INSURANCE; REQUIRING THE HEALTH CARE AUTHORITY TO ESTABLISH A CENTRALIZED CREDENTIALING APPLICATION PROCESS, INCLUDING A TIME FRAME FOR MEDICAID MANAGED CARE PROVIDERS TO LOAD INFORMATION ON CREDENTIALED PROVIDERS INTO THEIR PROVIDER PAYMENT SYSTEMS.

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

SECTION 1. Section 27-2-12.12 NMSA 1978 (being Laws 2003, Chapter 235, Section 4) is amended to read:

"27-2-12.12. [~~HUMAN SERVICES DEPARTMENT~~] HEALTH CARE AUTHORITY--[~~MANAGED CARE CONTRACT~~] CREDENTIALING PROVISIONS.--

A. No later than January 1, 2027, the [~~human services department~~] authority shall [~~negotiate with medicaid contractors to ensure that the contractors' credentialing requirements are coordinated with other credentialing processes~~

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~~required of~~] establish a centralized credentialing application process for individual providers. Under the centralized credentialing application process, individual providers shall only be required to submit a credentialing application to the authority. Each medicaid managed care contractor shall rely upon the application submitted to the authority to make credentialing decisions.

B. When an individual provider submits a credentialing application to the authority, a medicaid managed care contractor or a medicaid managed care contractor's agent shall:

(1) assess and verify the qualifications of a provider applying to become a participating provider within thirty calendar days of receipt of a complete credentialing application and issue a decision in writing to the applicant approving or denying the credentialing application;

(2) be permitted to extend the credentialing period to assess and issue a determination by an additional fifteen calendar days if, upon review of a complete application, it is determined that the circumstance presented, including an admission of sanctions by the state licensing board, an investigation of a felony conviction, a revocation of clinical privileges or a denial of insurance coverage, requires additional consideration;

(3) within ten calendar days after receipt of

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a credentialing application, send a written notification, via United States certified mail, to the applicant requesting any information or supporting documentation that the medicaid managed care contractor requires to approve or deny the credentialing application. The notice to the applicant shall include a complete and detailed description of all of the information or supporting documentation required and the name, physical address, email address and telephone number of a person who serves as the applicant's point of contact for completing the credentialing application process. Any information required pursuant to this section shall be reasonably related to the information in the application; and

(4) no later than thirty calendar days as described in Paragraph (1) of this subsection or an additional fifteen calendar days as described in Paragraph (2) of this subsection, load into the medicaid managed care contractor's provider payment system all provider information, including all information needed to correctly reimburse a newly approved provider according to the provider's contract. The medicaid managed care contractor or medicaid managed care contractor's agent shall add the approved provider's data to the provider directory upon loading the provider's information into the medicaid managed care contractor's provider payment system.

C. After a provider is initially credentialed by a medicaid managed care contractor, the medicaid managed care

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contractor shall not require subsequent credentialing more than once every three years.

D. The secretary shall promulgate rules to implement the provisions of this section.

E. Nothing in this section shall be construed to require a medicaid managed care contractor to credential a provider who does not meet the medicaid managed care organization's requirements to participate in the medicaid managed care organization's plan.

F. As used in this section:

(1) "credentialing" means the process of obtaining and verifying information about a provider and evaluating that provider when that provider seeks to become a participating provider; and

(2) "provider" means a physician or other individual licensed or otherwise authorized to furnish health care services in the state."

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