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HOUSE BILL 136

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

INTRODUCED BY

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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 CREDENTIALLED 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

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

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

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

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

25 (3) within ten calendar days after receipt of

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

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

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

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

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

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

10 F. As used in this section:

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

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