c. Shall provide for a second opinion from a qualified network provider, or arrange for the consumer to obtain a second opinion from a non-network provider if there is not another qualified network provider, at no cost to the consumer.

2. If the SE is unable to provide medically necessary covered services to a particular Medicaid consumer through a qualified network provider, the SE shall adequately and timely provide these services to the consumer through a non-network provider, for as long as the SE is unable to provide them through a network provider. The SE shall coordinate with the non-network provider with respect to payment. The SE shall ensure that the cost to the Medicaid consumer is no greater that it would be if the services were furnished through a network provider.

B. Requirements for Services for Native Americans

Nothing in this Section shall deny, diminish or result in withholding covered services to eligible Native American Medicaid and non-Medicaid consumers living on and off reservation. Although Native American needs are unique with respect to disparities and sovereignty, the SE shall recognize that services for Native Americans are also integral to all services delivered by the SE.

1. The SE shall recognize Native American Tribes, Nations, and Pueblos as inherently sovereign nations that have a government to government relationship with the State of New Mexico. The SE shall work with the State to carry out the New Mexico Health and Human Services Departments State-Tribal Consultation Protocol to seek, incorporate and utilize input and to support and expand behavioral health services for Native Americans.

2. The SE shall establish partnerships and enhance collaboration with Native American Tribes, Nations, and Pueblos in the design, implementation and modification of service delivery and program evaluation.

3. The SE shall design its organizational structure and provider enrollment process to respect and recognize the unique:

   a. Government to government relationships between the State and the Native American Tribes, Nations, and Pueblos;

   b. Indian health care system, which consists of Tribal programs and Tribal organizations, whether operating under Public Law 93-638 agreements (Tribal 638) or not, and the federal Indian Health Service (IHS).

4. The SE shall provide equitable access for Native American consumers, including consumers living off-reservation and in rural/remote tribal reservation areas, to covered services and non-clinical support services including but not limited to transportation, housing, respite, childcare, training opportunities, as well as consumer education on referral options to providers.

5. The SE shall seek and incorporate the views of Native American stakeholders (consumers and family members; BHPC Native American Subcommittee; providers; Region Six LCs; and advocates) in the design, implementation and modification of the behavioral health service delivery system.

6. The SE shall seek and incorporate input from the Tribes, Nations, and Pueblos; Indian Health Service (IHS); Region Six LCs; Native American consumers and family members; advocates for Native Americans; and providers who serve Native Americans to develop, strengthen, and support the behavioral health service delivery systems for Native Americans.

7. The SE shall have and implement policies and procedures ensuring culturally and linguistically appropriate supports and services for Native American consumers.

8. The SE shall promote, maintain and enhance the use of culturally appropriate traditional healing services to Native American consumers. However, the SE shall recognize that some Tribes, Nations and Pueblos may prefer to limit their participation because of cultural beliefs and to keep religious practices safeguarded. Services may include but are not limited to tribally-based community wellness and cultural teachings programs, ceremonies, sweat lodges, Native healers, etc.

9. The SE shall ensure that its staff have knowledge, experience, and training in providing behavioral health services to Native Americans and have experience with and knowledge of New Mexico tribal communities.

10. The SE shall preserve the current reimbursement system for providers serving Native American consumers with the goal of providing specific programs and services for Native Americans.

11. For Medicaid consumers, the SE shall:

    a. Contract with the Albuquerque Area IHS and Navajo Area IHS, and with Tribal 638 behavioral health providers that meet Medicaid minimum licensing and certification requirements for service delivery within New Mexico.

    b. Accept a provider employed by the IHS or Tribal 638 facility that holds a current license to practice in the United States or its territories as meeting licensure requirements.

12. For non-Medicaid consumers, the SE shall contract with Tribal and Urban Indian behavioral providers that meet minimum licensing/certification requirements for service delivery within New Mexico.

13. The SE shall develop, maintain and improve linkages with Tribes, the IHS, and the Bureau of Indian Affairs (BIA) in order to ensure appropriate coordination of care for Native American consumers utilizing services from those entities.

14. The SE shall provide technical assistance and training to IHS, Tribal, and Urban Indian behavioral health providers regarding provider enrollment, billing, credentialing standards, covered services, utilization review, prior authorizations, and quality of care. Training shall be conducted following any major program changes or at the Collaborative's request, but no less than two (2) times a year.

15. The SE shall provide support, technical assistance and training to the Region Six LCs.

16. The SE shall provide to Native American consumers comprehensive information of all covered services and providers available through the SE, including Native American providers and services. The SE shall ensure that Native American consumers are provided full information to access the most appropriate, accessible and quality services based on their individual needs and preferences.

17. The SE shall work with public, Tribal and BIA schools and Tribal judges and courts, regarding behavioral health care for Native American consumers and their families.

18. The SE shall provide a quarterly written report to the Collaborative, the co-chairs of the BHPC Native American Subcommittee, and the chair of the Region Six LCs on the planning and progress of the Region Six office and implementing the activities identified above.

19. The SE shall collect, track, and provide data to Native American Tribes, Nations and Pueblos, as well as Region Six LCs, on a regular monthly, quarterly, and annual basis. The SE shall provide assurances that this data shall be appropriately stored, analyzed, and released with any State and tribal approvals required.

C. **Requirements for Individuals with Special Health Care Needs**

1. The SE shall work with the Collaborative to develop new ways of identifying and serving ISHCNs.

2. The SE shall comply with NMAC 8.305.15.

3. With regards to ISHCNs, the SE shall:

   a. Have and implement policies and procedures to identify ISHCNs that reflects criteria specified by the Collaborative. These policies and procedures shall be prior approved by the Collaborative.

   b. Ensure that each identified ISCHN is assessed by an appropriate provider and that a treatment plan is developed (as appropriate) in accordance with applicable QM/QI and UM standards.

   c. Ensure that care coordination is available and offered to all ISHCNs and their parent and/or legal guardian or designated representative.

   d. Allow consumers to directly access providers as appropriate for the consumer's condition and identified needs.

   e. Ensure that the appropriate level of transportation is arranged for Medicaid ISCHNs, based on the consumer's clinical condition.

f. Incorporate into its consumer handbook a description of network providers and programs available to ISHCN.

4. The SE shall work with the Collaborative to develop and track performance measures specific to ISHCNs.

D. **Requirements for Services for People with Both a Developmental Disability and Mental Illness**

The SE shall ensure that consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders, receive covered services in a manner that meets their unique needs. The SE shall ensure that these consumers are offered care coordination services, which shall include coordinating with waiver providers and others who support persons with developmental disabilities and ensuring that these consumers have clinical multi-disciplinary teams. The SE shall provide technical assistance to providers serving this population to ensure the optimal delivery of covered services to consumers with both a developmental disability and a mental illness, including consumers with autism spectrum disorders.

3.11 CUSTOMER SERVICES

A. Member Services

The SE shall have a member services function that coordinates communication with consumers (their families, legal guardians, and/or designated representatives). The SE shall have sufficient staff to assist consumers in resolving problems and responding to consumer inquiries.

B. Consumer Handbook and Provider Directory

1. The SE shall provide Medicaid consumers a consumer handbook and provider directory within thirty (30) calendar days of the SE being notified by the State of the consumer's enrollment.
2. The SE shall send the consumer handbook and provider directory to non-Medicaid consumers upon request by the consumer or the State.
3. The consumer handbook shall include the following:
    - a. SE demographic information, including the organization's hotline telephone number;
    - b. Consumer rights and responsibilities (see Article 3.11.G);
    - c. Information on covered services;
    - d. Any restrictions on the consumer's freedom of choice among network providers;
    - e. Information regarding care coordination and coordination of care;
    - f. How to obtain emergency services, including:
        - i. The fact that the consumer has a right to use any hospital or other setting for emergency services; and
        - ii. What constitutes emergency condition, emergency services, and post-stabilization services;

g. Information on accessing covered services, including a discussion of the consumer's rights to self-refer; this shall include the right for a consumer to self-refer to any network provider and a Native American consumer to self-refer to an IHS or 638 provider;

h. A list of services for which prior authorization is required and the method of obtaining prior authorization;

i. The extent to which, and how, consumers may obtain covered services from non-network providers;

j. Information about the SE's grievance and appeals process, including how to file a grievance and/or appeal, timeframes, and the resolution process;

k. Information about the complaint and grievance processes available from providers, member agencies, and the Collaborative.

l. Information about HSD's fair hearing process (for Medicaid consumers), including right to file a request for an administrative hearing upon notification of the SE's action or following an appeal;

m. Information regarding advance directives, including a description of applicable state law;

n. Information regarding obtaining a second opinion (for Medicaid consumers);

o. Information on cost sharing, if any;

p. Additional information specified by the Collaborative; and

q. How to obtain, upon request, information on the structure and operation of the SE, physician incentive plans, and any other information specified by the Collaborative.

4. The provider directory shall be accurate and complete and include the following:

   a. SE addresses and telephone numbers; and

   b. A listing of behavioral health providers with the name, location(s), phone number, categories of service, and non-English languages spoken.

5. The consumer handbook and provider directory shall be accessible via the internet (see Article 3.20.K), and the SE's AVRS shall include provider directory inquiry.

6. The SE's Web-based provider directory and AVRS shall contain accurate and complete information on the provider network, including all of the information listed in Section 4.b above, and shall be shall be searchable by geographic location and service category. The SE shall update the Web-based and AVRS provider directory at least quarterly to reflect additions, deletions, and corrections.

7. The consumer handbook and provider directory shall be provided as requested by the Collaborative.

8. The consumer handbook and provider directory must be prior approved by the Collaborative.

9. The SE shall notify all Medicaid consumers at least once per year of their right to request and obtain member handbooks and provider directories.

10. The SE shall distribute notification of material changes in the administration of the SE, changes to the SE's provider network, significant changes in applicable state law, and any other information deemed relevant by the Collaborative to consumers 30 days prior to the intended effective date of the change.

C. **Requirements Regarding Written Materials**

1. The consumer handbook, provider directory, and all other educational material shall meet the following requirements:
   a. Materials shall be prepared in a manner and format that is clear and understandable to an individual who has completed no more than the sixth grade;
   b. Materials shall be in commonly understood language and avoid professional jargon;
   c. Materials shall be culturally sensitive;
   d. If there is a prevalent population of 5% of consumers, as determined by the SE or the Collaborative, materials shall be made available in the language of the identified prevalent population(s); and
   e. Materials shall be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency (e.g., large print, Braille, audiotapes/CD, and electronic format).

2. The SE shall notify consumers that written material is available in prevalent languages and alternative formats and how to access the materials in a prevalent language or alternative format.

3. The SE shall ensure that all of its web-based information for consumers is fully accessible according to national disability guidelines (e.g., Bobby-approved).

D. **Oral and Sign Language Interpretation Requirements**

1. The SE shall provide oral and sign language interpretation to consumers free of charge.

2. The SE shall ensure that oral interpretation is available in all non-English languages, not just those languages that are prevalent.

3. The SE shall notify consumers that oral and sign language interpretation is available, that language interpretation is available in any language, and how to access these services.

E. **Behavioral Health Education**

1. The SE shall provide a continuous program of behavioral health education without cost to consumers.

2. Behavioral health education may include but is not limited to education of consumers and family members regarding behavioral health diagnoses and implications, availability of and access to resources for information and services, and coordination with other disability services providers.

3. The behavioral health education program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction.

4. The SE shall work with the Collaborative to develop and implement behavioral health education programs consistent with the values of the Collaborative.

F. **Toll-Free Line**

1. The SE shall maintain a toll-free telephone line for providers, consumers, member agency staff, and other interested parties.

2. The SE may have separate lines/queues for providers, consumers, and/or other interested parties. However, the SE shall ensure that consumers can call the same number for both clinical and non-clinical calls.

3. The SE's call system shall not require a "touch-tone" phone and shall allow for communication with callers whose primary language is not English or who are hearing impaired. The SE's call system shall have TTY services and/or be accessible through the 711 telecommunication system.

4. The SE shall ensure that the line is adequately staffed to respond to non-clinical questions, at a minimum, from 8 A.M. to 5 P.M. Monday through Friday, except for state holidays. The SE shall have an automated system for non-clinical calls received during non-business hours. This automated system shall include, at a minimum, a voice mailbox for callers to leave a message. The SE shall ensure that messages are returned the next business day by an appropriate staff person.

5. The SE shall ensure that the line is adequately staffed to respond to clinical calls twenty-four (24) hours a day, three hundred and sixty five (365) days a year by behavioral health professionals who are culturally competent, are trained to screen crisis or emergency calls, and are able to assess the consumer's degree of acuity and need for treatment.

6. Any and all utilization management decisions shall meet the requirements of Article 3.12.J of this Contract.

7. The SE shall ensure that ninety percent (90%) of calls are answered within thirty (30) seconds. The SE shall ensure that the abandon rate for all calls waiting more than thirty (30) seconds shall not exceed 10%.

G. **Consumer Rights and Responsibilities**

1. The SE shall be required to comply with NMAC 8.305.8.15, Member [Consumer] Bill of Rights, and any other member agency's rights' statements.

2. The SE shall have and implement policies and procedures governing consumer rights and responsibilities, which shall include the following:

    a. Consumers have a right to obtain equitable treatment, respecting and recognizing the consumer's dignity and need for privacy.

    b. Consumers who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

    c. Consumers and their legal guardians have the right to make and have honored an advance directive consistent with state and federal laws.

    d. Consumers have a right to receive covered services in a non-discriminatory fashion.

    e. Consumers, their legal guardians and/or designated representatives, have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the consumer's condition and ability to understand.

    f. Consumers and, as appropriate, their families, legal guardians and/or designated representatives, have a right to participate with providers in decision-making regarding all aspects of their behavioral health care, including development of the course of treatment, acceptable treatments, and the right to refuse treatment.

    g. Consumers, their legal guardians and/or designated representatives, have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

    h. Consumers or their legal guardians or designated representatives have the right to informed consent.

    i. Consumers, their families, legal guardians and/or designated representatives, have a right to voice grievances about the care provided by the SE and to make use of the SE's grievance process (and the State's fair hearing process for Medicaid consumers) without fear of retaliation.

    j. Consumers, their families, legal guardians and/or designated representatives, have the right and the means to choose from among available networks providers within the SE's prior authorization requirements.

    k. Consumers, their legal guardians and/or designated representatives, have the right to request and receive a copy of their medical records in accordance with the applicable federal and state laws and regulations and the right to request that they be amended or corrected as specified in 42 CFR Part 164.

l. Consumers, their legal guardians and/or designated representatives, have the right to receive information about the SE, covered services, how to access covered services, and the SE's providers.

m. Consumers, their legal guardians and/or designated representatives, have the right to be free from harassment by the SE or its network providers in regard to contractual disputes between the SE and providers.

n. Consumers have a right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in federal or state regulations on the use of restraints and seclusion.

o. Consumers, their families, legal guardians, and/or designated representatives, to the extent possible, have a responsibility to provide information that the SE and its providers need in order to care for the consumer.

p. Consumers, their families, legal guardians, and/or designated representatives, to the degree possible, have a right and responsibility to participate in understanding their behavioral health problems and developing mutually agreed-upon treatment goals.

q. Consumers, their families, legal guardians, and/or designated representatives have a responsibility to follow the plans and instructions for care that they have agreed upon with their providers.

r. Consumers, their families, legal guardians, and/or designated representatives, have a responsibility to keep, reschedule, or cancel a scheduled appointment rather than to simply fail to keep it.

3. The SE shall ensure that each consumer (and/or as appropriate, his/her family, legal guardian and/or designated representative) is free to exercise his/her rights and that the exercise of those rights does not adversely affect the way the way the SE or its network providers treat the consumer (and/or his/her family, legal guardian and/or designated representative).

H. Consumer Notice of Provider Termination

The SE shall make a good faith effort to give written notice of termination of a network provider within 15 days after receipt or issuance of termination notice to each consumer that received services four times or more from the provider within the last twelve calendar months.

I. Advance Directives

The SE shall have and implement policies and procedures for advance directives. These policies and procedures shall include the following:

1. The SE shall provide adult consumers with written information on advance directive policies. This information shall include a description of applicable state law and regulation; consumer's rights under state law and regulation; the SE's policies respecting the implementation of the right to have an advance directive; and that complaints concerning noncompliance with advance directive requirements may be filed with the State survey and certification agency (currently DOH). This information shall reflect changes in state law and regulation as soon as possible, but no later than ninety (90) calendar days after the effective date of such change.
2. The SE shall honor advance directives within its UM protocols.
3. The SE shall educate its staff regarding advance directives and comply with the SE's policies and procedures and applicable state and federal law and regulations.
4. The SE shall ensure that consumers are offered the opportunity to prepare an advance request and that, upon request, are provided assistance in the process.
5. The SE shall not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed an advance directive.
6. The SE shall ensure that its providers:
   - a. Provide written information to adult consumers concerning their right to formulate advance directives; this information shall include the SE's policies and procedures for advance directives;
   - b. Document in the consumer's medical record whether or not the consumer has executed an advance directive;
   - c. Not discriminate against a consumer in the provision of care or in any other manner discriminating against a consumer based on whether the consumer has executed an advance directive;
   - d. Comply with federal and state law and regulations;
   - e. Educate staff and the community on issues concerning advance directives; and
   - f. Inform consumers that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency, currently DOH.

3.12 QUALITY ASSURANCE

A. Consumer and Family Advisory Board

1. The SE shall comply with NMAC 8.305.3.11 regarding a Consumer Advisory Board.
2. The SE's Consumer and Family Advisory Board shall keep a written record of all attempts to invite and include consumers in its meetings. The Board roster and minutes shall be made available to the Collaborative upon request.

3. The Consumer and Family Advisory Board shall consist of an equitable representation of consumers in terms of race, gender, special populations, and New Mexico's geographic areas.

4. The SE's Consumer and Family Advisory Board shall interact with the BHPC as directed by the Collaborative.

B. **Consumer and Family Member Involvement and Activities**

1. The SE shall support and help strengthen existing consumer and family networks and community peer advocacy organizations in expanding behavioral health consumer and family member peer advocacy, self-help programs, support networks, and peer-directed services.

2. The SE shall support efforts that involve utilizing consumers and family members in the development and implementation of peer-directed services. The SE shall work with the Collaborative in the development of peer support specialist and family and child support specialist services.

3. The SE shall conduct ongoing training and technical assistance for child, adult and family peers and shall include curricula that is culturally competent and sensitive to the needs of consumers and their families and that help to develop the skills necessary to match goals with services and to advocate for the needs of consumers and their families.

4. The SE shall attend at least two (2) statewide consumer and family member-driven or -hosted meetings per year if scheduled, that focus on consumer and family member or behavioral health service system issues and needs, in order to ensure that concerns are heard and addressed. These meetings shall be of the SE's choosing.

5. The SE shall ensure that consumers and family members, where appropriate, are presented with opportunities to proactively engage and participate in treatment planning and the behavioral health service delivery system, with a focus on the family as a potential change agent where consistent with the consumer's preferences and wishes.

6. The SE shall have multimedia announcements that identify opportunities that are available for consumers and family members and how consumers and family members may access those opportunities.

7. The SE, in partnership with the Collaborative, shall ensure outreach, recruitment, orientation and training and development of consumer and family member representatives to participate on its QM/QI Committee and shall encourage those representatives to attend the Consumer and Family Engagement (CAFÉ) Leadership Academy and the SE Recovery and Resiliency Department's Community Empowerment Training.

8. The SE shall foster open communication as well as collaborative relationships with State agency consumer/family liaisons. At a minimum, this shall involve established monthly mechanisms for briefing one another with regard to regional coordination of consumer and family member issues and peer advocacy, self-help programs and support networks, and peer-directed services, as well as exploring additional opportunities for coordination of technical assistance and quality improvement.

9. The SE shall ensure that its providers:

   a. Involve consumers in all aspects of treatment planning, development, and implementation, including making appropriate accommodations to ensure the participation of consumers and family members with cognitive and/or physical disabilities.

   b. Educate consumers about treatment options so that their ability to make informed choices regarding effective treatment is enhanced.

   c. Develop mechanisms for consumer and family member involvement in advocacy development and in quality activities that are culturally sensitive.

C. Quality Management and Quality Improvement (QM/QI) Program

1. The SE shall base its administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM) including: the recognition that opportunities for improvement are unlimited; that the QI process shall be data driven; requiring continual measurement of clinical and non-clinical effectiveness and programmatic improvements of clinical and non-clinical processes driven by such measurements; re-measurement of effectiveness and continuing development and implementation of improvements as appropriate; and reliance upon consumer and stakeholder input.

2. The SE shall comply with all sections of NMAC 8.305.8, Quality Management.

3. The SE shall comply with NMAC 8.305.8.12, including but not limited to:

   a. Base the QM/QI program on a model of continuous quality improvement, including, but not limited to the following:

      i. Demonstrate to the Collaborative that the results of QM/QI projects and reviews are used to improve the quality of service delivery;

      ii. Take appropriate action and document action to address provider and SE performance problems, as identified;

      iii. Incorporate sound quality studies, apply statistical analysis to data, and derive meaning from the statistical analysis; and

      iv. Perform a performance improvement project specific to ISHCN.

   b. Ensure that the QM/QI program is applied to the entire range of covered services and all major demographic population groups.

   c. Have an annual QM/QI work plan, prior approved by the Collaborative, that includes, at a minimum the following:

      i. Immediate objectives for each contract period and long-term objectives for the entire term of this Contract;

      ii. The scope of the objectives, projects, or activities planned, timeframes and data indicators for tracking performance;

    iii. Performance improvement projects, plans and activities consistent with federal and state laws and regulations, including 42 CFR §438.240; and

    iv. At least one (1) consumer safety indicator.

d. Institute QM/QI policies and procedures that emphasize and promote prevention and care coordination;

e. Develop and implement written QM/QI policies and procedures to address the following requirements:

    i. QM/QI program;

    ii. QM/QI committee;

    iii. An annual QM/QI work plan and an annual program evaluation that includes goals, objectives and structure, and that results in continuous quality improvement for consumers;

    iv. Confidentiality, including a provision that all materials concerning the care and treatment of members shall be made available to the Collaborative;

    v. Medical records and other records documentation;

    vi. Protocols for working with school-age consumers;

    vii. Consumer and network provider satisfaction surveys and other relevant consumer/family surveys;

    viii. Disease management protocols;

    ix. Continuity and coordination of services;

    x. Tracking and trending of consumer and provider grievances for early identification and resolution of systemic issues and potential trends;

    xi. Care coordination protocols for ISHCN and priority populations that reflect their comprehensive needs and service plan priorities, including coordination and integration of services; and

    xii. Provide quality oversight of network providers as necessary to ensure quality of services but in no way as a replacement for the licensing and certification oversight otherwise provided by the State.

f. Establish a committee to oversee and implement QM/QI activities.

g. Have an annual QM/QI evaluation of overall effectiveness to demonstrate improvements in the quality of clinical care and non-clinical services to consumers. The SE shall submit an annual written evaluation that includes, but is not limited to the following:

    i. A description of on-going and completed QM/QI activities;

    ii. Trending of measures to assess performance in quality of clinical care and non-clinical services;

    iii. An analysis of whether or not there have been demonstrable improvements in the quality of clinical care and non-clinical services; and

    iv. Incorporation of findings of overall effectiveness in the development of the following year's plan.

  h. Designate an SE staff person responsible for compliance with all the QM/QI requirements.

  i. Be responsible for the QM/QI program and not delegate this responsibility to subcontractors.

4. The SE shall conduct QM/QI activities in accordance with any applicable requirements of member agencies, funding source requirements and/or policies issued by the Collaborative.

5. The SE's QM/QI program shall include activities that provide continuous monitoring and regular evaluation of clinical services provided, the adequacy of covered services, the provider network, and the SE's administrative operations (including but not limited to member services, grievances and appeals, provider relations, UM, call center, and care coordination). The SE shall ensure that corrective action is implemented as necessary to ensure continuous quality improvement in clinical and non-clinical services.

6. The SE's QM/QI program shall incorporate findings from external evaluations of the SE (e.g., C/FSP and the EQRO report).

7. Based on findings from the QM/QI program, including any applicable external evaluations, the SE shall identify opportunities for improvement, initiate targeted quality interventions, and monitor the intervention's effectiveness.

8. The SE shall submit to the Collaborative a written report whenever a finding indicates a significant system problem or warrants serious corrective action. The report shall include the finding and proposed corrective action.

9. The SE shall, as directed by the Collaborative, conduct selected quality studies jointly with the MCOs and/or other key entities. No more than two (2) studies per year will be required.

10. The SE shall conduct an annual provider satisfaction survey and shall incorporate the results of the survey into the SE's QM/QI program.

11. The SE's QM/QI program shall include ongoing monitoring, tracking, and trending of provider performance, and, as necessary, the SE shall provide training and technical assistance and ensure that appropriate interventions, including corrective actions are implemented (see Articles 3.13.D and E).

12. The SE shall communicate the results of QM/QI activities and provider reviews with appropriate providers and use this information to improve the performance of the providers, including technical assistance, corrective action plans, and follow-up activities as necessary.

13. The SE's QM/QI program shall include conducting data-driven evaluations of clinical practices to improve quality of care. The SE shall demonstrate how the SE has facilitated improvements.

14. The SE shall ensure that its high-volume providers, as defined by the SE and approved by the Collaborative, have a current QM/QI plan for tracking and improving quality of care, access, appropriateness of care, consumer/family satisfaction, and outcomes. The providers' plans shall describe the roles of provider agency staff, consumers, and family members in development and implementation of the QM/QI plan.

15. The SE shall ensure that its high-volume providers submit their annual QM/QI plan to the SE no later than August 1 each Contract Year and submit an annual QM/QI report that summarizes activities and findings, including opportunities for improvement. The SE shall report to the Collaborative, upon request, the status of provider compliance with this requirement.

16. The SE shall conduct an annual on-site clinical audit of a sample of high-volume providers QM/QI plan performance. This task shall be shared by the SE's QM/QI and Provider Relations departments. The sample shall be determined in collaboration with the Collaborative.

17. In the development, implementation, and evaluation of its QM/QI program the SE shall ensure the exchange of information (as allowable by state and federal law) and input by stakeholders, including but not limited to consumers, family members, advocates, the BHPC, LCs, MCOs, providers, Collaborative staff, and member agency staff.

18. The SE's QM/QI committee shall include, at a minimum, representation from provider agencies, consumers, family members, the BHPC, and the Collaborative.

19. The SE shall share regularly findings of the QM/QI program, including data and analysis of performance measures (see Article 3.12.D), with the Collaborative, the BHPC, LCs, and member agencies.

20. The SE shall, upon request and as specified by the Collaborative, communicate non-confidential QM/QI findings to network providers, consumers, families and others.

21. The SE's QM/QI program shall include leadership by executive clinical staff of the SE, including the Chief Medical Officer/Medical Director, Vice President of Clinical Operations, and Vice President of QM/QI.

D. **Performance Measures**

1. The SE shall measure and track performance measures, report on performance measures at intervals defined by the Collaborative, and incorporate performance measures as part of its QM/QI program.

    a. Performance measures shall include those required by the federal government or specified by the Collaborative.

b. The Collaborative will use performance measures to evaluate the SE's clinical and non-clinical performance, ability to improve clinical and non-clinical performance, and to take corrective actions as needed to improve performance.

c. The SE shall:

   i. Collect and manage data necessary to support performance measurement activities, including establishment of the baseline and tracking of change in performance over time;

   ii. Design sound quality studies, apply statistical analyses to data, and determine the significance of the data collected;

   iii. Adhere to the timely and accurate collection of data to calculate the SE's performance rate for those performance measures identified by the Collaborative;

   iv. Identify specific interventions that the SE shall use to improve performance measures;

   v. Achieve demonstrable improvement in each performance measure during the course of the Contract;

   vi. Perform subsequent measurement and assessment of the ongoing effectiveness of specific interventions; and

   vii. Demonstrate to the Collaborative that the results of performance measurement activities are used to improve the quality of service delivery with appropriate providers. When the SE determines that there are provider performance problems, the SE shall take and document appropriate action.

2. Subject to prior approval by the Collaborative, the SE shall calculate baselines for each performance measure. The Collaborative, working with the SE, shall establish annual targets for each performance measure.

3. The SE shall submit reports of the SE's progress relating to each performance measure.

4. The SE shall be accountable for the achievement of the performance measure targets identified by the Collaborative. Failure to achieve performance targets may result in sanctions pursuant to Article 8. The Collaborative will identify the performance targets for which sanctions are applicable.

5. The SE shall participate with the Collaborative and other stakeholders in the ongoing development and use of performance measures.

6. Over the course of the Contract period, individual performance measures may be deleted, added, or modified as determined by the Collaborative.

7. As specified by the Collaborative, performance measure demographics will include breakout by disability group, specifically Autism Spectrum Disorders (ASD), cognitive disabilities, brain injury, deaf or hard of hearing, blind and visually impaired, and physical disabilities.

8. Performance measures shall include the Governor's Performance & Accountability Measures, which include but are not be limited to the following:

   a. Percent of individuals committing suicide or reporting suicidal attempts, specifically suicide rates for youth ages 15-19 and 20-24; persons aged 20 years and older; Native Americans, adults over the age of 65; and percent of youth reporting they have considered or attempted suicide;

   b. Percent of adults with serious mental illness in competitive employment of their choice;

   c. Percent of children/adolescents with severe emotional disturbances receiving services who are successful in school;

   d. Percent of individuals with mental illness and/or substance abuse disorders receiving services with decent, safe, affordable housing;

   e. Percent of people receiving substance abuse treatment who demonstrate improvement on three (3) or more domains on the Addiction Severity Index (ASI);

   f. Percent of adults presenting with psychiatric issues who are screened for substance abuse; and percentage of adults presenting with substance abuse issues who are screened for psychiatric issues;

   g. Percent of adults and youth served who have contact or repeat contact with the adult or juvenile justice system or adult corrections;

   h. Percent of persons receiving substance abuse services who are arrested for DWI or use of illicit substances;

   i. Percent of individuals discharged from inpatient facilities who receive follow-up services at seven (7) days and thirty (30) days;

   j. Percent of consumers and families reporting satisfaction with services;

   k. Number of individuals served annually in substance abuse and mental health programs, by ethnicity, region, age and risk level (high risk);

   l. Percent and number of ISHCN served by major disability group (ASD, DD, brain injury, deaf and hard of hearing, blind, and physical disabilities)

   m. Number of individuals served in evidence-based practice programs;

n. Percent of children with improved functional assessments between admission and discharge in CYFD-funded community-based programs;

o. Percent of JJS consumers in facilities assessed as having behavioral health needs on intake who receive behavioral health services;

p. Percent of all payments made to providers within the required timeframes;

q. Percentage of individuals with co-occurring disorders (COD) receiving services, the percentage of individuals diagnosed with COD who have treatment goals in both the mental health and substance abuse realms, and appropriate discharge planning that considers an individual's future COD service needs;

r. Percent of expenditures for community-based services operated by consumers/families as a share of total community-based services expenditures;

s. Percent of individuals in rural and frontier locations with access to an appropriate behavioral health provider within sixty (60), and ninety (90) miles, respectively;

t. Number of programs/agencies using community health workers, peer specialists and practitioners designed specifically for persons who are Native American or Spanish speaking; and

u. Prevention performance measures developed by the SE with the approval of the Collaborative.

E. Consumer Satisfaction Survey and New Mexico Consumer/Family Satisfaction Project

1. The Collaborative conducts an annual adult and child/family consumer satisfaction survey based on the national Mental Health Statistics Improvement Project (MHSIP), hereafter known as the NM Consumer/Family Satisfaction Project (C/FSP). The SE shall cooperate in conducting this survey as requested by the Collaborative.

2. The SE may conduct a consumer/family satisfaction survey separate from the C/FSP. Such survey, including the survey instrument and methodology, shall be prior approved by the Collaborative, and the SE shall submit a report to the Collaborative summarizing the methodology and findings, including opportunities for improvement.

F. Behavioral Health Management

The SE shall comply with NMAC 8.305.8.12 regarding health management systems.

G. **External Quality Review**

1. The State shall retain the services of an external quality review organization (EQRO) in accordance with §1902(c)(30)(C) of the Social Security Act. The SE shall cooperate fully with the EQRO and demonstrate to that organization the SE's adherence to HSD/MAD's managed care regulations and quality standards as set forth in MAD Policy.

2. The State shall also contract with an EQRO to audit a statistically valid sample of the SE's UM decisions, including authorizations, reductions, terminations and denials. This audit is intended to determine if authorized service levels are appropriate with respect to accepted standards of clinical care. The EQRO shall also audit the SE's QM/QI program and review performance measures and performance improvement projects, based on CMS criteria.

3. The SE shall participate in various other tasks identified by the State that shall enable it to gauge performance in a variety of areas, including care coordination and treatment of special populations.

4. The SE shall utilize technical assistance and guidelines offered by the EQRO, unless otherwise agreed upon by the parties.

5. The EQRO retained by the State shall not be a direct competitor of the SE.

H. **Standards for Access**

1. The SE shall ensure the accessibility and availability of behavioral health providers for each medically, clinically or psychosocially necessary service.

2. The SE shall comply with NMAC 8.305.8.18.

3. The SE shall submit documentation to the Collaborative, as requested, giving assurances that it has the capacity to serve the expected number of consumers in accordance with the Collaborative's access standards. This documentation shall be in a format acceptable to the State.

4. The SE shall provide access to the full array of covered services. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

5. The SE shall maintain and update as necessary its Service Access Plan, which shall describe the SE's system for consumer access to services. The plan will be reviewed during regular quarterly meetings that include the SE and the Collaborative, and shall be revised as required by the Collaborative.

6. The SE shall ensure that in each region of the State there is an array of covered services that allow consumers to be served within the least restrictive setting and in close proximity to their places of residence, with preference given to in-state providers.

    a. The SE can include out-of-state providers for those consumers who require services not available from in-state providers.

    b. For each child residing in an out-of-state residential facility, the SE shall develop a plan, approved by the Collaborative, to provide medically or clinically necessary and appropriate services in-state.

7. The SE shall report to the Collaborative any high-volume network providers (as defined by the SE) that are not accepting new consumers.

8. For non-Medicaid consumers and non-Medicaid services to Medicaid consumers, the SE shall use diagnostic criteria and risk factors (see Article 3.5) to prioritize access to covered services.

9. The SE shall ensure that the following appointment standards are met:

    a. For non-urgent, non-emergent behavioral health care, the request-to-appointment time shall be no more than fourteen (14) days, unless the consumer requests a later time.

    b. For urgent behavioral health care, appointments shall be available within twenty-four (24) hours.

    c. For crisis services, face-to-face appointments shall be available within two (2) hours.

10. The SE shall report to the Collaborative on the compliance of providers in meeting the appointment standards in section 9 above. The methodology and timeframe must be approved by the Collaborative.

I. Clinical Practice Guidelines and Evidence-Based Practices

1. The SE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of services for acute and chronic behavioral health care conditions.

2. The SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of consumers.

3. The clinical practice guidelines shall be evidence-based.

4. The SE shall involve network providers who are appropriate to the clinical issue, as well as consumers and family members affected by the guidelines, in the development and adoption of clinical practice guidelines.

5. The SE shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two (2) years, and updating them as necessary.

6. The SE shall distribute the guidelines to the appropriate providers, provide them to the Collaborative upon request, and make them available to consumers, families, and the public upon request.

7. The SE shall periodically assess provider performance against at least three guidelines and determine consistency of decision-making based on the clinical practice guidelines.

8. The SE's decision-making in UM, consumer education, interpretation of covered services, and other areas shall be consistent with these guidelines.

9. The SE shall implement targeted disease management protocols and procedures for chronic diseases and/or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied consumers. These disease management programs shall be prior approved by the Collaborative.

10. The SE, in the delivery of covered services, shall work with the Collaborative to continue and improve the ongoing implementation of evidence-based practices, including promising and best practices for persons with developmental disabilities, mental illness, and autism spectrum disorder and including the identification of evidence-based or promising practices that are culturally appropriate.

J. Utilization Management (UM)

The SE shall:

1. Comply with NMAC 8.305.8.13 regarding Standards for Utilization Management. References to "medical necessity" in NMAC 8.305.8.13 shall be read to include clinical and psychosocial necessity as those terms are defined in Article 2 of this Contract. References to "member" in NMAC 8.305.8.13 shall be read as "consumer" (as defined in Article 2 of this Contract) and shall include the consumer's family, legal guardian, and/or designated representative as appropriate. All requirements in NMAC 8.305.8.13 regarding providing notice to providers shall include notice to the consumer and/or consumer's family, legal guardian, and/or designated representative as appropriate.

2. Manage the use of limited resources, maximize the effectiveness of care by evaluating clinical appropriateness, and authorize the type and volume of services through fair, consistent and culturally competent decision-making processes while ensuring equitable access to care and a successful link between care and outcomes. The consumer's treatment plan priorities and prolonged service authorizations applicable for individuals with chronic conditions shall be considered in the decision-making process.

3. Define and submit annually to the Collaborative a written copy of the UM program description, UM plan, and UM evaluation, which shall include but not be limited to:

    a. A description of the program structure and accountability mechanisms;

    b. Specific indicators that will be used for periodic performance tracking and trending as well as processes or mechanisms used for assessment and intervention; and

    c. An evaluation of the overall effectiveness of the UM plan, an overview of the UM activities and the impact of the UM plan on the quality of management and administrative activities. The review and analysis shall be incorporated in the development of the following year's UM plan.

4. Submit to the Collaborative for prior approval a description of all services that will require prior authorization and all UR criteria that will be utilized for prior authorization and other UM decisions. The SE shall submit to the Collaborative for prior approval any changes to the services that must be prior authorized or the UR criteria.

5. Develop and implement policies and procedures for review of utilization decisions to ensure their basis in sound clinical evidence and that they conform to medical, clinical and psychosocial necessity criteria.

6. Develop and implement policies and procedures to issue extended prior authorization for any covered service expected to be required on an on-going basis to exceed six (6) months. These services shall be authorized for an extended period of time and the SE shall provide for a review and periodic update of the course of treatment, as indicated.

7. Ensure the involvement of appropriate, practicing providers in the development of UM procedures.

8. Except as otherwise provided in this Contract (see, e.g., Article 3.9.G), approve or deny covered services for routine/non-urgent and urgent care requests and provide notice within the timeframes stated in NMAC 8.305.8.13. These required timeframes are not to be affected by a "pend" decision. The SE's decision-making timeframes shall accommodate the clinical urgency of the situation and not delay the provision of covered services to consumers for lengthy periods of time.

9. Develop and implement policies and procedures by which UM decisions may be appealed by consumers or their representatives in a timely manner, which shall include all applicable requirements and timeframes for submission based on CMS and State law and regulations.

10. Ensure that, consistent with 42 CFR §§438.6(h) and 422.208 compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue services to any consumer.

11. Evaluate network provider satisfaction with the UM process as part of its provider satisfaction survey (see Article 3.13.A).

12. Provide the Collaborative timely access to the SE's UM review documentation for purposes of compliance audits and/or other contract oversight activities.

13. Establish, maintain and monitor a UM system that includes an efficient decision-making process and the application of clear and consistent criteria for admission, continued stay and discharge into each service with criteria appropriate to each consumer population and funding source.

    a. The SE shall establish and implement a UM system that follows national standards, promotes quality of care, adherence to standards of care, the efficient use of resources, consumer choice, and the identification of service gaps within the service system.

b. The SE's UM system shall:

  i. Ensure that consumers receive services based on their current condition and effectiveness of previous treatment;

  ii. Ensure that services are based on the history of the problem/illness, its context, and desired outcomes;

  iii. Assist consumers, their families, legal guardians, and/or designated representatives in choosing among providers and available treatments and services; and

  iv. Emphasize relapse and crisis prevention, not just crisis intervention.

c. The SE shall educate its UM staff and network providers in the application of its UM system, clearly articulating the criteria to be used in making UM decisions and describing specific care coordination functions.

d. The SE shall develop protocols, procedures and criteria for assessing medical, clinical or psychosocial necessity as appropriate to the consumer and the funding source, making level-of-care determinations, and authorizing services. Such protocols shall incorporate the definition of medical, clinical and psychosocial necessity as defined in Article 2 of this Contract, the ASAM patient placement criteria, member agency service manuals, and other guiding documents.

e. The SE shall ensure that all medically, clinically, or psychosocially necessary referrals are arranged and coordinated by either the referring provider or by the SE's care coordination unit.

14. Maintain records (both hard and electronic) that verify its utilization management activities and compliance with UM requirements.

15. Specify which covered services will and will not require prior authorization and how the SE will conduct initial, concurrent and retrospective reviews. In all circumstances in which services are authorized at a more or less intensive level of care than requested, the SE shall ensure that the level and duration of such services are appropriate.

16. Not require prior authorization for the following:

  a. Evaluations performed for children, adolescents or young adults up to age twenty-one (21) preparing to transition out of a twenty-four (24) hour facility, including juvenile correctional facilities or as court-ordered.

  b. School-based services except to prevent duplicate services or payment for the same service for the same child.

17. Ensure that services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.

18. Not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the consumer's diagnosis, type of illness, or condition.

19. Honor advance directives within its UM protocols.

20. Ensure that consumers have an optimal choice of providers consistent with their treatment needs and available providers.

21. For each level of care, describe the amount and type of choice consumers (their families, legal guardians, and/or designated representatives) will be offered with respect to providers, services, and time and location of providers/services. The SE shall also describe the options available when the SE's initial selection of provider(s) of services proves unsatisfactory to the consumer, family, legal guardian, and/or designated representative.

22. Receive prior approval of the Collaborative before delegating any of the SE's UM functions to subcontractor(s) and remain fully responsible for all UM decisions and quality of care.

23. Ensure that a board certified psychiatrist, to the extent possible certified in both child/adolescent and adult services, has substantial involvement in the design and implementation of the UM program.

24. Upon request, provide UM decision criteria to providers, consumers, their families, and the public.

25. Ensure the consistent use of written policies and procedures regarding UM by all SE staff performing UM functions.

26. Demonstrate that all UM staff have been trained and are competent in working with individuals with co-occurring psychiatric and addictive disorders.

27. Ensure that staff who make UM decisions are Master's degree clinicians or Registered Nurses with a minimum of five (5) years of clinical experience in the mental health and/or substance abuse fields. This includes Master's equivalent Certified Nurse Practitioners and Clinical Nurse Specialists with a psychiatric certification, in addition to other licensed Master's level clinicians, such as LISWs, LPCCs, or psychologists. The SE may also use Licensed Alcohol and Drug Abuse Counselors (LADACs).

28. Ensure that approvals during business hours are made by a New Mexico licensed clinician. Approvals after hours may be authorized by a non-New Mexico licensed clinician but shall be reviewed by a New Mexico licensed clinician on the next business day.

29. Ensure that denials based on lack of medical or clinical necessity are made by a board certified psychiatrist licensed in New Mexico. Denials for children and adolescents shall be made by a child/adolescent psychiatrist. A board certified child/adolescent psychiatrist is preferred, but a board eligible child/adolescent psychiatrist is acceptable.

30. When a request for a service is denied, assist the consumer and his/her provider in finding the appropriate level of care.

31. Clearly document and communicate the reason(s) for UM decisions (approval/denial) to the requesting provider and to the consumer, family, legal guardian, or designated representative. See Article 3.12.K regarding Notice of Action.

32. For concurrent review of inpatient care, make a decision within one (1) business day of obtaining the required information.

33. Make every effort to obtain all relevant information needed to make an authorization determination based on medical, clinical, or psychosocial necessity, depending on the consumer, service type, and fund source.

    a. The SE shall have a written description identifying the information required to support UM decision-making.

    b. The SE shall document that relevant information is gathered consistently to support UM decision-making.

    c. The SE shall inform providers in writing regarding the information requirements for UM decision-making and shall provide this information to consumers and their families upon request.

34. Comply with NMAC 8.305.8.13.I, Evaluate and use of new technology, and ensure that appropriate providers, consumers, family members, advocates, and members of the BHPC and LCs participate in this process. The inclusion of new treatment technology or new uses of existing technology shall be prior approved by the Collaborative.

35. As part of its UM process, establish and implement policies and procedures relative to the closure of case files. The SE shall ensure that its network providers adhere to the SE's policies and procedures for closure of case files, in conformance with member agency requirements.

36. Have information systems that enable the paperless submission of prior authorization and (if applicable) other utilization management-related requests, and when applicable the automated processing of said requests. These systems shall also provide status information on the processing of said requests. These shall be interfaced as needed to care coordination systems to facilitate care coordination and direction to appropriate services.

K. Notice of Action

The SE shall notify the requesting network or non-network provider, and give the consumer (and/or his parent, legal guardian and/or designated representative) written notice of any decision by the SE to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notice, including language and format, content, and timing, shall meet the requirements set forth in 42 CFR §438.404. See also Article 3.15.D.1 of this Contract.

L. Critical Incident Management

1. The SE shall develop and implement a statewide critical incident management system that identifies and tracks critical incidents, corrects case-specific issues, and addresses identified systems' issues that place consumers at risk.

2. The SE shall immediately report to the Collaborative any incident that could place a consumer at immediate risk. The SE shall report all critical incidents that impact health and safety to the Collaborative within 24 hours of notification/becoming aware of the incident.

3. The SE's critical incident management system shall be in accordance with Collaborative and member agency guidelines and incident management protocols and must be prior approved by the Collaborative.

4. Critical incidents include but are not limited to incidents that may have a serious impact on consumers, provider staff, member agencies, or the public, or may bring about adverse publicity.

5. The SE shall track and analyze critical incidents. The SE shall use this information to identify potential and actual quality of care and/or health and safety issues, including both case-specific and systemic issues, and shall implement appropriate interventions.

6. The SE shall ensure that network providers report critical incidents within the timeframes specified by the SE. This shall include both initial reporting of the incident and a follow-up report providing additional detail regarding the incident. For critical incidents that impact health and safety, the maximum timeframe for providers to report the incident shall be 24 hours and the maximum timeframe for providers to submit a follow-up report shall be 48 hours.

7. The SE shall ensure that providers with a critical incident conduct an internal critical incident investigation and submit a report on the investigation within the timeframe specified by the SE. The SE shall review the provider's report and take corrective action with the provider as necessary.

8. The SE shall provide appropriate training and take corrective action as needed to ensure provider compliance with critical incident requirements.

9. As specified by the Collaborative, the SE shall submit regular reports to the Collaborative regarding critical incidents, including but not limited to suicide; other death; attempted suicide; involuntary hospitalization; detention for protective custody; detention for alleged criminal activity; elopement; and any incident resulting in significant physical harm to a consumer or to others allegedly caused by a consumer.

3.13 PROVIDERS

A. Provider Network Development and Management

1. The SE shall comply with the requirements in NMAC 8.305.6.9, General Network Requirements, including, but not limited to the following:

   a. The SE shall establish and maintain a comprehensive network of providers willing and capable of serving consumers.

b. The SE shall provide all covered services in a timely manner. The SE is solely responsible for the provision of covered services and shall ensure that its network includes providers in sufficient numbers to ensure that all covered services are available in accordance with access standards.

c. The SE shall contract with the full array of providers necessary to deliver covered services and shall take into consideration the characteristics and behavioral health care needs of consumers. In establishing and maintaining the network of appropriate providers, the SE shall consider the following:

    i. The numbers of network providers who are not accepting new consumers;

    ii. The geographic location of providers compared with eligible consumers, considering distance and travel time; and

    iii. Whether the location provides physical access for consumers, including consumers with disabilities.

d. The SE shall notify the Collaborative in writing within five (5) business days of unexpected changes to the composition of its provider network that has a significantly negative effect on consumers or on the SE's ability to deliver covered services. The SE shall notify the Collaborative in writing of anticipated material changes in the SE's provider network at least thirty (30) days prior to the change, or as soon as the SE knows of the anticipated change. A notice of change shall contain:

    i. The nature of the change;

    ii. How the change affects delivery of or access to covered services; and

    iii. The SE's plan for maintaining access and the quality of consumer care.

e. The SE shall develop and implement policies and procedures on provider recruitment and termination. The recruitment policies and procedures shall describe how the SE responds to a change in the network that affects access and its ability to deliver services in a timely manner.

f. The SE:

    i. Shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

    ii. Shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

        iii. Shall not decline to include providers in its network without giving the affected providers written notice of the reason for its decision;
        iv. Shall not be required to contract with providers beyond the number necessary to meet the needs of consumers;
        v. Shall be allowed to use different reimbursement amounts for different specialties or for different providers within the same specialty so long as a justifiable reason (e.g., access, volume) for doing so exists;
        vi. Shall not employ or subcontract with providers excluded from participation in federal health care programs;
        vii. Shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with the SE's responsibility to consumers; and
        viii. Shall not be required to contract with providers who are ineligible to receive reimbursement under Medicaid fee-for-service.

2. The SE shall maintain complete, accurate, and up-to-date information on all network and out-of-network providers.
    a. This information shall include all of the data elements specified by the Collaborative.
    b. The SE shall transmit initial and recurring provider files, in a format and method to be mutually agreed upon with the Collaborative. The provider files shall contain new providers, changes to existing providers, and termination of provider status.
    c. The SE shall assign provider types and specialties to providers in the provider file according to applicable Collaborative criteria and definitions. These criteria and definitions include but are not limited to the use of the provider's licensure/certification, and not the service that the provider is rendering, when coding a particular provider's specialty.
    d. Where applicable, the SE shall use the NPI to identify providers and send a separate record for each unique combination of NPI, provider type, and ZIP code. Alternatively, the SE shall send the tax ID (FEIN or SSN) for all providers and, for atypical providers, send a separate record for each unique combination of FEIN/SSN, provider type, and ZIP code.
3. The SE shall not discriminate and/or retaliate against providers who file grievances or appeals.
4. The SE shall not limit or interfere with providers' efforts to lobby and/or air opinions and concerns regarding their interactions with the SE or their business interests.
5. The SE shall not prohibit or otherwise restrict a network or non-network provider from advising a consumer who is a patient of the provider about the health status of the consumer or medical care or treatment for the

consumer's condition of disease, regardless of whether the care or treatment is a covered service, if the provider is acting within the lawful scope of practice. This subsection, however, shall not be construed as requiring the SE to provide, reimburse, or provide coverage of any service if the SE:

a. Objects to the provision of a counseling or referral service on moral or religious grounds, provided that the SE notifies consumers of these objections at the earliest possible time;

b. Notifies the Collaborative within ten (10) business days after the effective date of this Contract of its current policies and procedures regarding its objection to providing such counseling or referral services based on moral or religious grounds, or within fifteen (15) calendar days after it adopts a change in policy regarding such counseling or referral services;

c. Can demonstrate that the service in question is not included as a covered service required by this Contract; or

d. Determines that the recommended service is not medically, clinically, or psychosocially necessary under the SE's policies and procedures, and in accordance with the definition set forth above.

6. The SE shall have and implement policies and procedures regarding any referral processes. The SE referral process shall be effective and efficient and not impede timely access to and receipt of services.

7. The SE shall make every effort to reduce administrative burdens on providers. The SE shall develop and use consistent and user-friendly clinical and non-clinical forms and procedures, including but not limited to forms and procedures for credentialing/recredentialing, daily operations, assessments, UM, service authorization, billing, and reporting. The SE shall use electronic formats and web-based applications to the extent practical. The SE shall use national standards as the basis for forms and processes where possible.

8. The SE or a provider may initiate a change of provider when the consumer's (or legal guardian's or designated representative's) behavior toward the provider is such that the provider has made all reasonable efforts to accommodate the consumer or guardian or designated representative and address the consumer or guardian or designated representative problems, but those efforts have been unsuccessful. If the SE initiates such change in provider, the consumer or guardian or designated representative has the right to file a grievance.

9. The SE shall conduct an annual provider satisfaction survey, the results of which shall be incorporated into the SE's quality management and quality improvement (QM/QI) program. Survey results shall be reported to the Collaborative.

10. The SE shall establish and maintain a process for addressing provider grievances and appeals (see Article 3.15.J).

11. The SE shall actively solicit input from its network providers in an effort to improve and resolve problem areas related to service delivery and the SE's administrative functions and incorporate this information into the SE's QM/QI program.

12. The SE shall work with consumers, families, providers, disability organizations, and academic institutions to improve provider capacity and expertise.

13. The SE shall work with and support the Collaborative to ensure the availability of basic behavioral health services within each Region, including Comprehensive Community Support Services, outpatient counseling/therapy, and pharmacotherapy services.

14. The SE shall evaluate, on at least an annual basis, the array of network providers and covered services needed in each of the six regions of the State. The SE shall take into account any service needs identified by the Local Collaboratives, the BHPC, or the Collaborative. The SE shall submit a report of its findings to the Collaborative.

B. Provider Credentialing and Recredentialing

1. The SE shall have and implement policies and procedures that comply with NMAC 8.305.8.14, Standards for Credentialing and Recredentialing, as well as any other applicable credentialing/recredentialing requirements from member agencies.

2. The SE shall ensure that all network providers meet the credentialing and recredentialing requirements of all applicable Collaborative standards and policies. Requirements and procedures shall apply to both existing as well as new providers.

3. The SE shall use a Collaborative-approved application for network participation. Any changes to the application must be prior approved by the Collaborative.

4. The SE shall designate a credentialing committee or other peer review body to make recommendations regarding credentialing/recredentialing decisions.

5. The SE shall complete the credentialing process within sixty (60) days from receipt of a completed application with all required documentation unless there are extenuating circumstances.

6. The SE shall ensure that credentialing/recredentialing requirements and processes are streamlined and enable providers to move across agencies and settings without unnecessary restrictions, once credentialing has been granted. The SE's credentialing/credentialing requirements shall recognize and promote approaches to services such as consumer- and family-run programs, Native American healing practices and programs, traditional curanderismo, and other legally acceptable programs.

7. The SE shall have a process for receiving input from providers regarding the credentialing and recredentialing process.

8. For independent practitioners, the SE shall:
    a. Identify the types of practitioners who shall be credentialed/recredentialed. This shall include, at a minimum, all psychiatrists and other licensed independent practitioners.
    b. Use a Collaborative-approved application form, which includes at a minimum, the items specified in NMAC 8.305.8.14 as well as a history of consumer complaints and their resolution.
    c. As part of the initial credentialing process, verify, at minimum the items listed in NMAC 8.305.8.14 regarding primary source verification.
    d. As part of the initial credentialing process, check that the applicant is not on the List of Excluded Individuals & Entities (LEIE). The SE shall not contract with excluded practitioners.
    e. As part of the initial credentialing process, comply with provider disclosure requirements pursuant to 42 CFR §§455.104 and 105.
    f. As part of the initial credentialing process, conduct an onsite visit to the offices of potential high-volume behavioral health care practitioners.
        i. The SE shall determine the method for identifying high-volume behavioral health providers, which shall be prior approved by the Collaborative.
        ii. The SE shall develop and document a structured review to evaluate the provider's site relative to the performance standards identified by the SE and approved by the Collaborative.
        iii. The site visit shall include an evaluation of the provider's medical record keeping practices at each site for conformity with the SE's standards.
    g. Recredential network providers at least every three (3) years.
9. For organizational providers, the SE shall:
    a. Conduct initial and ongoing assessments of all organizational providers. Organizational providers include but are not limited to residential treatment centers, clinics, including community mental health centers, twenty-four-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals.
    b. As part of the initial assessment, check that the applicant is not on the List of Excluded Individuals & Entities (LEIE). The SE shall not contract with excluded providers.
    c. As part of the initial assessment, comply with provider disclosure requirements pursuant to 42 CFR §§455.104 and 105.
    d. As part of the initial assessment, confirm that the provider is in good standing with state and federal regulatory bodies and has been certified by the appropriate state certification agency, when applicable.

e. As part of the initial assessment, if accreditation is required by the Collaborative or the SE, confirm that the appropriate accrediting body has accredited the provider or that the provider has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time. If accreditation is not required, the SE shall conduct an onsite quality assessment.

f. At least every three (3) years, confirm that the provider is in good standing with state and federal regulatory bodies and, as applicable, is accredited by the appropriate accrediting body, certified by the state certification agency, and/or meets the SE's standards of participation.

10. The SE shall maintain records, that verify its credentialing activities, including primary source verification, and compliance with credentialing/recredentialing requirements.

11. The SE shall credential DOH facilities, as allowed by regulations, and as requested by those agencies, to provide behavioral health services.

C. **Provider Reimbursement**

1. The SE shall be responsible for reimbursing network and non-network providers in accordance with the requirements of this Contract (see Article 3.18 and Article 6).

2. Except as otherwise provided in this Contract (see Article 6.15), for Medicaid services the SE shall negotiate the reimbursement methodology and rate with providers. The methodology may include but is not limited to fee-for-service, case rates, or subcapitation. If the SE changes an existing reimbursement methodology or rate, it shall take steps to transition the provider to the new methodology/rate and prevent adverse financial consequences to the provider.

3. For non-Medicaid services (to both Medicaid and non-Medicaid consumers), the SE shall use the providers and reimbursement methodology and rate specified by the Collaborative.

4. Regardless of a provider's reimbursement methodology, the SE shall ensure that it receives required reports and data (e.g., encounter data) from network providers.

5. The SE shall develop and implement a plan, approved by the Collaborative, for moving toward a uniform system of service rates across Collaborative funding streams, specifically utilizing the Collaborative common service definitions.

   a. The plan shall be presented to the Collaborative for approval no later than that the date specified by the Collaborative.

   b. The SE shall work with Collaborative staff, as appropriate, in the implementation of its plan.

   c. The SE shall present any substantive changes to its plan to the Collaborative for review and approval prior to making those changes.

d. The SE shall include in its plan:

  i. The changes it will need to make to its fiscal and claims payment systems to implement its plan;

  ii. How it will give providers the support and training that may be necessary in making the transition to the system;

  iii. How it will minimize impact on providers where more uniformity will result in a lower reimbursement rate for a particular provider, provider type, or geographic area; specifically, how it will phase in rate changes that will likely lower a high-volume or specialty provider's overall revenue by more than ten percent (10%) in any six (6) month period; and

  iv. How its uniform rate structure will assist access in rural and frontier areas.

e. The SE shall make progress toward the goals of more uniform rates through the implementation of this plan and shall submit a semi-annual report to the Collaborative on its progress.

6. The SE shall evaluate administrative costs at the provider level and, in consultation with the Collaborative, develop a plan to reduce these costs.

7. Notwithstanding the SE's right to negotiate rates with individual providers for Medicaid services, the SE shall give the Collaborative at least sixty (60) days notice prior to any proposed changes that would broadly affect provider rates. No proposed changes shall go into effect without giving the Collaborative the right to hold public meetings and otherwise obtain public input related to the proposed changes. Thereafter, the SE shall give the Collaborative notice of the effective date of the proposed changes.

D. **Provider Education, Training and Technical Assistance**

1. The SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials to its network providers. The SE shall provide information to providers that will:

  a. Inform providers of the conditions of participation with the SE;

  b. Inform providers of their responsibilities to the SE and to consumers;

  c. Inform providers of how the SE defines high-volume provider and whether or not a provider meets that definition;

  d. Inform providers of fund-specific policies and procedures (including but not limited to Medicaid), including information on covered services and services specific to the needs of ISHCN and other special populations;

  e. Inform providers regarding billing requirements and rate structures and amounts;

f. Inform providers regarding cultural and linguistic competency and how to access educational opportunities for providers and their staff on cultural and linguistic competency;

g. Provide information on credentialing and recredentialing, prior authorization, and referral processes, and how to request and obtain a second opinion for Medicaid consumers;

h. Inform providers on how to access care coordination services for ISCHNs and other special populations as well as Medicaid services not covered by this contract for Medicaid consumers;

i. Inform providers regarding the delivery of the federally mandated Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services;

j. Furnish providers with information on the SE's internal provider grievance process;

k. Inform providers about their responsibility to report critical incident information and the mechanism to report such information; and

l. Inform providers regarding the delivery of services to children in the custody of the State, including but not limited to issues related to consent, progress reporting, and potential for court testimony.

2. The SE shall contact all network providers in-person or by phone on a regular basis to update high-volume providers on SE initiatives and communicate pertinent information.

3. The SE shall provide training and technical assistance to network providers to assist in professional development, increase provider knowledge regarding covered services, improve their business and financial practices, and reduce administrative costs.

4. The SE shall provide initial education and training to providers prior to their delivery of services under this Contract. This education and training shall include but not be limited to: the role of and relationship among the SE, the BHPC, the LCs, and the Collaborative; provider clinical responsibilities such as conducting assessments, developing treatment plans and discharge plans, and fund-specific requirements; provider administrative responsibilities such as registering non-Medicaid consumers, being credentialed/recredentialed, and complying with service authorization, billing, and reporting requirements.

5. The SE shall provide regular, ongoing provider education and training throughout the contract period to address clinical issues and improve the service delivery system, including but not limited to assessments, treatment plans, discharge plans, evidence-based practices, models of care, and fund-specific requirements.

6. The SE shall identify training needs and work with the Collaborative to identify additional training needs and prioritize training needs.

7. The SE shall develop training plans and materials and conduct training to address issues/topics identified by the Collaborative.

8. The SE shall develop training plans on a regular basis, which must be prior approved by the Collaborative. The training plans shall specify the training topic, the targeted providers, the content of the training, and the training schedule (including dates/times and locations).
9. The SE shall offer training regionally and at different times of the day in order to accommodate providers' schedules.
10. The SE shall provide training in a culturally competent manner.
11. The SE shall develop and implement a process to evaluate the effectiveness and outcomes of the training provided.
12. The SE shall provide technical assistance to network providers as determined necessary by the SE or the Collaborative, including one-on-one meetings with providers. This technical assistance shall be provided in a culturally competent manner.
13. The SE shall submit a quarterly training activity report to the Collaborative. This report shall provide a summary of each training event by title, location(s), number of registrants, number of participants, number and type of CEUs offered, and a summation of the participants' satisfaction surveys. The report shall also include any cancelled event with an explanation of the cancellation.
14. The SE shall report biannually on the effectiveness of the training provided and recommendations for additional training.
15. The SE shall maintain a record of its training and technical assistance activities, which shall be made available to member agencies upon request.
16. The SE shall incorporate its training plans, their implementation, and their evaluation into its QM/QI program.
17. The SE shall comply with NMAC 8.305.6.17.

E. Provider Agreement and Provider Monitoring

1. <u>Provider Agreements</u>
    a. The SE shall execute provider agreements (contracts) with each network provider.
    b. The provider agreement shall include the following:
        i. All applicable provisions from Article 19.
        ii. Medical record and case file documentation and access requirements consistent with all applicable state and federal requirements;
        iii. Requirements regarding disaster behavioral health planning and response (see Article 3.9.Q);
        iv. Requirement that the provider accept all referrals and shall not refuse to provide covered services to a consumer who needs services that are within the provider's scope of clinical expertise;

v. Requirement that the provider participate in and cooperate with the SE's QM/QI program and all monitoring activities;

vi. Reporting requirements, including but not limited to requirements for reporting data, critical incidents, and other information required by the Contract;

vii. Requirements regarding fraud and abuse, including reporting of potential fraud or abuse and cooperation with any investigation;

viii. Third party liability requirements;

ix. Provisions regarding remedial action for provider non-compliance with requirements, including corrective action and sanctions, up to and including contract termination; this shall include but not be limited to sanctions for failure to comply with reporting requirements; and

x. Any provisions necessary to ensure that services are provided consistent with the terms and conditions of this Contract.

c. The SE and the State shall share all provider contracts as requested.

2. <u>Provider Monitoring</u>

a. The SE shall ensure that its providers are in compliance with both clinical and non-clinical requirements of this Contract and the provider agreement. The SE shall conduct ongoing monitoring of its providers (see also Article 3.12.C). This monitoring shall include regular provider reviews and/or on-site audits to determine provider compliance with clinical and non-clinical requirements. The SE shall provide the Collaborative with copies of provider reviews and/or audit schedules, upon request, so that the Collaborative may participate if it so desires. The SE shall provide training (see Article 3.13.D) and technical assistance and implement corrective action as needed to ensure that providers are in compliance with applicable requirements.

b. The SE shall ensure that all providers maintain the certification and training necessary to provide the services they offer. The SE shall utilize QM/QI data in conducting provider re-credentialing, re-contracting and/or performance evaluations.

c. The SE shall have policies and procedures for altering the conditions of the provider's participation with the SE based on issues of quality of care and service. At a minimum, these policies and procedures shall comply with NMAC 8.305.8.14, Imposition of remedies.

d. The SE shall evaluate the business practices of its providers, provide technical assistance in implementing sound business practices/improving current practices, implement appropriate interventions/corrective action plans, and conduct appropriate follow-up activities.

e. The SE shall monitor the financial stability of its providers, provide technical assistance in implementing sound financial management strategies, implement appropriate interventions/corrective action plans, and conduct appropriate follow-up activities. The SE shall notify the Collaborative if any provider is having significant financial difficulties.

f. The SE shall ensure that all providers are in compliance with applicable provisions of the Americans with Disabilities Act, 42 USC §§12101, et seq., ("ADA"), and its regulations. This shall include entrances, restrooms, business offices, therapy locations and all service delivery sites.

g. The SE shall ensure that all providers have TTY services and/or are accessible through the 711 telecommunication system.

h. The SE shall ensure that providers submit all data and reports required by the SE and/or the Collaborative. The SE shall generate reports and track provider performance in terms of data and report completion/submission, create profiles illustrating each provider's compliance, and implement corrective action plans with providers to improve accuracy and timeliness and to monitor the impact of the corrective action.

i. At the request of the Collaborative, the SE shall conduct provider audits, including both desk and onsite audits, to evaluate provider performance.

F. Telehealth Requirements

1. In providing services under this Contract, the SE shall employ broad-based utilization of statewide access to HIPAA-compliant telehealth service systems including, but not limited to, access to TTYs and 711 Telecommunication Relay Services.

2. The SE shall:

   a. Follow State guidelines for telehealth equipment or connectivity.

   b. Attend meetings of the Telehealth Commission as requested.

   c. Follow accepted HIPAA and 42 CFR Part 2 regulations that affect telehealth transmission, including but not limited to staff and provider training, room setup, security of transmission lines, etc. The SE shall have and implement policies and procedures that follow any federal or state security and procedure guidelines.

   d. Identify, develop, and implement training for accepted telehealth practices.

   e. Provide to the Collaborative performance measure data specific to telehealth encounters.

   f. Participate in the needs assessment of the organizational, developmental, and programmatic requirements of telehealth programs.

g. Report to the Collaborative on the telehealth outcomes of pilot or other telehealth projects.

h. Ensure that telehealth services meet the following shared values of the New Mexico Telehealth Commission:

   i. Ensuring competent care with regards to culture and language needs.

   ii. Networked sites are equally distributed across regions of the state, including Native American sites, for both clinical and educational purposes, with focus on development of regional networks in line with regional breakout of state agencies.

   iii. Ensuring coordination of telehealth and technical functions at either end of network connection.

3.14 CULTURAL COMPETENCY

A. The SE shall develop, implement, evaluate, and update a Cultural Competency Plan encompassing all types of disability for itself and for all network providers to ensure that consumers and their families, including individuals with disabilities, receive covered services that are culturally and linguistically appropriate to meet their needs.

B. The SE shall submit its Cultural Competency Plan to the Collaborative on an annual basis for approval.

C. The SE's Cultural Competency Plan shall describe how the SE shall ensure that covered services are culturally and linguistically appropriate and shall incorporate nationally accepted Cultural Competence standards.

D. The SE shall develop and implement policies and procedures that implement the Cultural Competency Plan.

E. The SE shall develop and implement a plan for sign language interpreter, oral interpreter and written translation services to meet the needs of consumers (their families, legal guardians, and/or designated representative) who have a hearing impairment or whose primary language is not English. The SE shall use qualified medical interpreters, if available.

F. The SE shall identify community advocates, agencies, and providers to assist individuals who have a hearing impairment or are non-English or limited-English speaking and/or that provide other culturally appropriate and competent services, including outreach and referral activities.

G. The SE shall incorporate cultural competence into assessment, treatment planning, utilization management, its QM/QI program, and discharge planning.

H. The SE shall identify resources and interventions for high-risk behavioral health conditions found in certain cultural groups.

I. The SE shall develop and incorporate cultural and linguistic competency requirements into provider agreements and subcontracts.

J. The SE shall recruit and train a diverse staff and leadership that are representative of the demographic characteristics of consumers.

K. The SE shall select a staff member with appropriate training and experience to serve as the Director of Diversity Initiatives. The Director shall implement cultural community support system activities as well as evaluation activities. The Director shall also work with the SE's QM/QI Department to monitor, evaluate and address diversity issues within the SE and the delivery system.

L. The SE shall conduct an initial and annual organizational self-assessments of culturally and linguistically competent-related activities and is encouraged to integrate cultural and linguistic competence-related measures into its QM/QI activities.

M. The SE shall work with the Collaborative to appoint individuals within each member agency to form a workgroup with the SE to identify and make recommendations regarding systems-wide issues, indicators, goals, and objectives related to the development of a culturally and linguistically competent behavioral health system.

N. The SE shall submit a quarterly progress report to the Collaborative outlining progress in implementing activities outlined in the SE's Cultural Competency Plan. This report shall identify difficulties and barriers and a plan for remediation of same, as appropriate.

O. The SE shall participate with the State's efforts to promote the delivery of covered services in a culturally and linguistically competent manner to all consumers, including consumers who have a hearing impairment, consumers with limited English proficiency, consumers who have a speech or language disorders, consumers who have physical disabilities, consumers who have developmental disabilities, consumers who have differential abilities, and consumers who have diverse cultural and ethnic backgrounds.

3.15 GRIEVANCE AND APPEALS

A. Definitions

For purposes of this Article 3.15, the following definitions shall apply:

"**Appeal**" is a request for review by the SE of an SE Action.

"**Action**" is the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner; or the failure of the SE to complete the authorization request in a timely manner as defined in 42 CFR §438.408. An untimely service authorization constitutes a denial and is thus considered an Action.

"**Expedited Resolution of an Appeal**" means an expedited review by the SE of an SE Action.

"**Grievance**" is a consumer's expression of dissatisfaction about any matter or aspect of the SE or its operation other than an SE Action.

"**Notice**" of an SE Action shall contain: (1) the Action the SE has taken or intends to take; (2) the reasons for the Action; (3) the consumer's or the provider's right to file an appeal of the SE's Action through the SE; (4) a Medicaid consumer's right to request an HSD/MAD Fair Hearing and what that process would be; (5) the procedures for exercising the rights specified; (6) the circumstances under which Expedited Resolution of an appeal is available and how to request it; and (7) a Medicaid consumer's right to have benefits continue pending resolution of the Appeal, how to request the benefits be continued, and the circumstances under which the consumer may be required to pay the costs of these services.

The consumer, legal guardian if the consumer is a minor or is an incapacitated adult, or a representative of the consumer as designated in writing to the SE, or the representative of a deceased consumer's estate, has the right to file a Grievance; an Appeal of an SE Action; or request an HSD/MAD Fair Hearing (for Medicaid consumers), on behalf of the consumer or deceased consumer. A provider acting on behalf of the consumer and with the consumer's written consent may file a Grievance and/or Appeal of an SE Action. An HSD/MAD Fair Hearing may be requested by a Medicaid consumer prior to, concurrent with, subsequent to, or in lieu of a Grievance.

B. General Requirements for Grievance and Appeals

The SE shall:

1. Comply with NMAC 8.305.12 and 8.349.2 regarding Grievances and Appeals.
2. Implement written policies and procedures describing how the consumer may register a Grievance or an Appeal with the SE and how the SE resolves the Grievance or Appeal and meet all the requirements in the HSD/MAD Program Manual or other member agency requirements.
3. Provide a copy of its policies and procedures for resolution of a Grievance and/or Appeal to all network providers.
4. Have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capacity.
5. Name a specific individual designated as the SE's consumer Grievance Coordinator with the authority to administer the policies and procedures for resolution of a Grievance and/or Appeal, to review patterns/trends in Grievances and/or Appeals, and to initiate corrective action.
6. Ensure that the individuals who make decisions on Grievance and/or Appeals are not involved in any previous level of review or decision-making. The SE shall also ensure that behavioral health care practitioners with appropriate clinical expertise will make decisions for the following:
    a. An Appeal of an SE denial that is based on lack of medical, clinical or psychosocial necessity;
    b. An SE denial that is upheld in an Expedited Resolution; and
    c. A Grievance or Appeal that involves clinical issues.
7. Ensure that punitive or retaliatory action is not taken against a consumer or provider that files a Grievance and/or Appeal, or against a provider that supports a consumer's Grievance and/or Appeal.