State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
STATE COVERAGE INSURANCE (SCI)

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
New Mexico Human Services Department is proposing regulation updates to the State Coverage Insurance (SCI) Program regarding the following: to simplify the financial eligibility determination for self-employed individuals; to incorporate relevant updates that were effective with the Managed Care regulation updates effective 7/1/07, and to effect various other minor revisions to clarify regulatory language.

VI. REGULATIONS
These proposed regulation changes refer to Chapters 8.262.400 NMAC, 8.262.500 NMAC, 8.306.1 NMAC, 8.306.3 NMAC, 8.306.5 NMAC, 8.306.6 NMAC, 8.306.7 NMAC, 8.306.12 NMAC, 8.306.13 NMAC, 8.306.15 NMAC and 8.306.16 NMAC of the Medical Assistance Program Manual. This register and the proposed changes are available on the Medical Assistance Division web site at http://www.hsd.state.nm.us/mad. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective June 1, 2008.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 1:00 p.m., April 11, 2008, in the HSD Law Library at Pollon Plaza, 2009 S. Pacheco Street, Santa Fe, New Mexico. Parking accessible to persons with physical impairments will be available.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m., on April 11, 2008. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

PAMELA S. HYDE, J.D., SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 400 RECIPIENT POLICIES

8.262.400.7 DEFINITIONS:

A. **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, modification, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or a failure to provide a service in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

B. **Authorized representative:** An individual or entity for whom or for which the applicant has signed a release of confidentiality and to whom notices will be sent.

C. **Benefits:** SCI-covered services provided by the SCI-participating MCO and for which payment is included in the capitation rate, as defined in 8.262.600 NMAC.

D. **Capitation:** A per-member, monthly payment to an MCO that covers contracted services and is paid in advance of service delivery. It is a set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed in units of "per member per month" (PMPM).

E. **Catastrophic coverage:** Insurance coverage for specific catastrophic events, such as death, fire, flood, and some medical conditions.

F. **Category:** A designation of the automated eligibility system. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

G. **Cost-sharing:** Premiums and copayments owed by the member based on income group category.

H. **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to 5% of the program participant's countable income.

I. **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable, are met.

J. **Eligibility:** The process of establishing that SCI residency, citizenship or alien status, health insurance coverage, income, living arrangement, and age requirements are met, as defined in this part and 8.262.500 NMAC.

K. **Employer:** An employer with fifty or fewer eligible employees on a full or part-time basis**.**

L. **Employer group:** A group of employees employed by an eligible employer who [~~receive~~] receives SCI benefits through the employer.

M. **Employee:** A person employed by an employer who participates in the SCI health benefit plan.

N. **Employer enrollment period:** Employer's standard practice for new and annual health insurance enrollment.

O. **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care coverage. Enrollment encompasses selection of an MCO, notification of the selection to the MCO, and timely payment of premiums, as required, as designed by the MCO.

P. **Eligibility letter:** A notice of SCI eligibility and the potential for SCI coverage contingent upon enrollment with a SCI participating MCO. The letter will include start and end dates of eligibility, the requirement to enroll before coverage will begin, and the need to enroll 30 days subsequent to the month of issuance of the enrollment letter. The letter will also notify the member of the federal poverty level subcategory and of the responsibility to track out-of-pocket expenditures for SCI cost sharing.

Q. **Fifth degree of relationship:** The following relatives are within the fifth degree of relationship to a dependent child:

(1) father (biological or adopted);

(2) mother (biological or adopted);

(3) grandfather, great grandfather, great-great-grandfather, great-great-great-grandfather;

(4) grandmother, great grandmother, great-great-grandmother, great-great-great-grandmother;

(5) spouse of child's parent (stepparent);

(6) spouse of child's grandparent, great grandparent, great-great-grandparent, great-great-great-grandparent (step-grandparent);

(7) brother, half-brother, brother-in-law, stepbrother;

(8) sister, half-sister, sister-in-law, stepsister;

(9) uncle of the whole or half blood, uncle-in-law, great uncle, great-great uncle;

(10) aunt of the whole or half-blood, aunt-in-law, great aunt, great-great aunt;

(11) first cousin and spouse of first cousin;

(12) son or daughter of first cousin (first cousin once removed) and spouse;

(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or

(14) nephew/niece and spouses.

(15) ***Note:*** A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

R. **Fiscal agent (medicaid fiscal agent):** An entity contracted by the state medicaid program to sort and process eligibility information as well as pay fee-for-service and capitation claims.

S. **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

T. **Group of one:** Individuals who enroll without an employer group but report self-employment.

U. **Health insurance:** Insurance against loss by sickness or bodily injury. The generic term for any forms of insurance that provides lump sum or periodic payments in the event of bodily injury, sickness, or disease, and medical expense. This includes but is not exclusive [~~to~~] of: medicare part A or medicare part B, medicaid, CHAMPUS, and other forms of government health coverage.

V. **Hearing or administrative hearing:** An evidentiary hearing that is conducted so that evidence may be presented.

W. **Income groupings- 0-100%, 101-150%, and 151-200% of federal poverty levels:** These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

X. **Individual:** A person who enrolls in SCI who is not a member of an eligible employer group and pays the premium amount designated for both the employee share, if applicable based on income, and the employer share, or has that amount paid on his/her behalf by another entity.

Y. **Individual health plan**: Health insurance coverage purchased by an individual from an insurer offering individual healthcare benefit policies.

[~~Y.~~] Z. **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage and coordinate and receive payment at actuarially sound payment rates for the delivery of specified services to enrolled members from a certain geographic area.

[~~Z.~~] AA. **Member:** An eligible member enrolled in an MCO.

[~~AA.~~] BB. **Member month:** A calendar month in which a member is enrolled in an MCO.

[~~BB.~~] CC. **Notice:** A written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the circumstances under which the service may be continued if a hearing is requested.

[~~CC.~~] DD. **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

[~~DD.~~] EE. **Premium- employer:** A specific monthly payment payable to the MCO by employers who enroll their employees in SCI at a rate set by the department. This amount may be paid by an individual member not in an employer group in order to participate in SCI. Subject to available funding, the state may allocate funds to assist certain eligible individuals with payment of the employer premium contribution and will notify eligible individuals of such assistance. Premiums cannot be refunded.

[~~EE.~~] FF. **Premium- employee:** A specific monthly payment payable to the MCO calculated by the department based on a subcategory of eligibility representing an income grouping. 062-0-100% FPL, 062-101-150% FPL, 062-151-200% FPL. Premiums and copayments cannot be refunded.

[~~FF.~~] GG. **Qualifying event:** Termination of employment for any reason; loss of eligibility for health insurance benefits due to reduction in work hours; loss of health insurance coverage due to death, divorce or legal separation from spouse, loss of dependent status; moving to or from another state.

[~~GG.~~] HH. **SCI (State coverage insurance):** the New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver granted to the state by the centers for medicare and medicaid services (CMS).

[~~HH.~~] II. **Shoebox method:** The method under which an SCI member is responsible for tracking, and submission of a request for verification of total expenditures for himself, based on SCI employee premiums and copayments for purposes of establishing that the cost-sharing maximum amount has been met.

[~~II.~~] JJ. **Voluntary drop:** The act of voluntarily terminating or discontinuing health insurance coverage.

[8.262.400.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 500 INCOME AND RESOURCE STANDARDS

8.262.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS: Methodology for establishing financial eligibility for state coverage insurance (SCI) uses New Mexico works cash assistance definitions of income, rules for income availability, and exempt income with the exception of 8.102.520.11C and 8.102.520.12B, which refer to the methodology for determining self-employment income.

A. **Income test:** In order to be eligible for SCI, countable income (after applicable exemptions and disregards) must meet the SCI income limit for the appropriate family size. The SCI income standards are based on 200% of federal poverty levels (FPLs). SCI uses New Mexico works income definitions and methodologies with the exception of 8.102.520.11C and 8.102.520.12B. (Also see 8.102.520.8 NMAC through 8.102.520.15 NMAC). SCI eligibility and cost-sharing levels will be determined based on one income test using countable income (after applicable exemptions and disregards).

B. **Determining income for self-employed individuals:** Reports to state and federal tax authorities are the usual indicators of self-employment income (refer to 8.100.130.14 B (2) (b) NMAC for other acceptable documents that may be submitted to determine self-employment income). To determine self-employment income, apply the following methodology:

(1) Use the amount listed on line 31 (net profit or loss) of Schedule C or line 36 (net profit or loss) of Schedule F of the most recent or previous year's 1040 Income Tax Return to determine annual self-employment income;

(2) Divide the amount by 12 or by the applicable number of months in business to determine monthly self-employment income.

[~~B.~~] C. **Payment standard increments:** Payment standard increments for nonsubsidized housing living arrangements and clothing allowance do not affect the SCI eligibility process, i.e., the eligibility limits for income are not increased by the amount of the nonsubsidized housing or clothing allowance payment increments.

[~~C.~~] D. **Excess hours work deduction:** This deduction is not applicable to SCI.

[~~D.~~] E. **SCI category designation:** SCI eligibles will be assigned one category of eligibility (062). The income grouping (subcategory) will control the employee premium and copayment amounts.
[8.262.500.9 NMAC - N, 7-1-05; A, 3-1-06; A, 6-1-08; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 1 GENERAL PROVISIONS

8.306.1.7 DEFINITIONS: The state of New Mexico is committed to reducing the number of uninsured working New Mexico residents and improving the number of small employers offering health benefit plans by implementation of a basic health coverage health insurance benefit provided by contracted managed care organization with cost sharing by members, employers and the state and federal governments. This section contains the glossary for the New Mexico state coverage insurance policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

(1) **Abuse:** Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to SCI, in reimbursement for services that are not medically necessary, or in services that fail to meet professionally recognized standards for health care. Abuse also includes member or member practices that result in unnecessary costs to SCI.

(2) **Action:** The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, modification or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review [~~of~~] by the managed care organization (MCO) of an MCO action as defined above in Paragraph (2) of Subsection A of 8.306.17. [~~Refers to an individual or entity appealing to a higher authority, as for a decision. An appeal is a request to change a previous decision made by the MCO. An appeal can be made to the contractor for review of a contractor action by a member or a provider on a member's behalf. An appeal may also be a request for a new hearing or a request for a transfer of a case from one court to a higher court.~~]

(4) **Appeal, provider:** A request by a provider for review by the MCO of an MCO action related to the denial of payment or an administrative denial.

[~~(4)~~] (5) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the member meeting the clinical criteria for the requested SCI service(s) and/or level of care.

B. Definitions beginning with letter "B":

(1) **Behavioral health planning council (BHPC):** Refers to the council created by HB 271 to meet federal advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council.

(2) **Behavioral health:** Refers to mental health and substance abuse, including co-occurring disorders.

(3) **Behavioral health purchasing collaborative (the collaborative):** [~~Refers~~] refer to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271 effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies including 15 direct service [~~provision~~] providers and funding agencies, including the human services department.

(4) **Benefit package:** SCI covered services that must be furnished by the MCO and for which payment is included in the capitation rate.

(5) **Benefit year:** The year beginning with the month of enrollment in an MCO and payment of designated premiums if applicable and continuing for a period up to 12 continuous months as long as enrollment requirements are met.

(6) **Broker:** A person, partnership, corporation or professional corporation appointed by a health insurer licensed to transact business in New Mexico to act as its representative in any given locality for the purpose of soliciting and writing any policy or contract insuring against loss or expense resulting from the sickness of the insured.

C. Definitions beginning with letter "C":

(1) **Capitation:** A per-member, monthly payment to an MCO that covers contracted services and is paid in advance of service delivery. It is a set amount of money received or paid out, based on membership rather than on services delivered. It is usually expressed [~~in units of~~] "per member per month" (PM/PM).

(2) **Care coordination:** [~~Is an~~] An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral and/or physical health care needs on an as needed basis. It is member-centered, family-focused when appropriate, culturally competent and strengths-based. Care coordination can help to ensure that the physical and behavioral health needs of the SCI population are identified and services are provided and coordinated with the individual member and family, if appropriate. Care coordination operates within the MCO with a dedicated care coordination staff, functioning independently, but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances. Clinical decisions shall be based on the medically necessary covered services and not on fiscal considerations. The care coordinator coordinates services within the physical health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility will lie with the care provider from the condition that is most acute at the time.

(3) **Case management**: Refers to a person or team of people who provide outreach to customers, provide information to them about services, work with them to develop a service plan, assist in obtaining needed services, supports and entitlements and advocate on their behalf. General case management is designed to access, coordinate and monitor services. [~~It is a set of functions intended to ensure that individuals receive the services they need in a timely, appropriate, effective, efficient and coordinated fashion. It is individually-centered, family/member-focused when appropriate, culturally competent and strengths-based. The general purposes of case management are to access, coordinate and monitor services and to assess an individual's progress toward specific goals. Services typically include assessment, plan of care/service plan, development and review, advocacy, referral and linkage to services, housing activities, the individual's income maintenance activities, facilitation and natural helping resources and coordination of physical health and social services and outcomes.~~]

(4) **Category:** A designation of the automated eligibility system. SCI has one designated category (062) and three income groupings that are assigned to an individual based on their income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

(5) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. [~~A clean claim may include errors originating in the state's system~~]. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

(6) **Client:** An individual who has applied for and been determined eligible for SCI. A "client" may also be referred to as a "member," "customer," or "consumer", or "program participant".

(7) **CMS:** Centers for medicare and medicaid services.

(8) **Continuous quality improvement (CQI):** CQI is a process for improving quality that assumes opportunities for improvement are unlimited; is customer-oriented, data driven, and results in implementation of improvements; and requires continual measurement of implemented improvements and modification of improvements, as indicated.

(9) **Coordinated Long-Term Services (CLTS):** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers. The CLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The CLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities and medically-fragile waiver programs.

[~~(9)~~] (10) **Cost-sharing:** Premiums and co-payments owed by the member based on income group category.

[~~(10)~~] (11) **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to 5% of the program participant's countable income.

[~~(11)~~] (12) **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable are met.

[~~(12)~~] (13) **Cultural competence:** Cultural competence refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which the MCO gives another entity the authority to perform certain functions on its behalf. The MCO retains full accountability for the delegated functions.

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by SCI, not being on the MCO Pharmacy Drug List, or due to provider noncompliance with administrative policies and procedures established by either the SCI MCO or the medical assistance division, except pharmaceutical services which the formulary process covers.

(3) **Denial-clinical:** A non-authorization decision at the time of an initial request for a SCI service or a Pharmacy Drug List request based on the member not meeting medical necessity for the requested service[~~, except pharmaceutical services which are covered by the formulary process~~]. The utilization management (UM) staff may recommend an alternative service, based on the member's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

(4) **Disease Management plan:** A comprehensive plan following nationally recognized components for chronic disease interventions including population identification/stratification process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

[~~(4)~~] (5) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of an individual SCI member from membership in the requesting MCO, as determined by HSD, on a case-by-case basis.

[~~(5)~~] (6) **Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of an individual SCI member as determined by HSD on a case-by-case basis, from one SCI MCO to a different SCI MCO during a member lock-in period.

[~~(6)~~] (7) **Durable medical equipment (DME):** Equipment that can withstand repeated use, is primarily used to serve a medical purpose, is not useful to individuals in the absence of an illness or injury and is appropriate for use at home.

E. Definitions beginning with letter "E":

(1) **Emergency:** An emergency condition is a physical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body function or serious dysfunction of any bodily organ or part.

(2) **Employer:** An employer with fifty or fewer eligible employees on a full or part time basis.

(3) **Employer group:** A group of employees employed by an eligible employer who receive SCI benefits through the employer or a self-employed person who will be considered a group of one.

(4) **Employee:** A person employed by an employer who participates in the SCI health benefit plan.

(5) **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO member, client, customer or consumer.

(6) **Enrollee:** A SCI recipient who is currently enrolled in a managed care organization.

(7) **Enrollee rights:** Rights which each SCI enrollee is guaranteed.

(8) **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care coverage. Enrollment encompasses selection of an MCO, notification of the selection to the MCO, and timely payment of premiums to the MCO as determined by the MCO.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within 72 hours of the requested appeal, which includes an expedited review by the MCO of an MCO action.

[~~(8)~~] (10) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise [~~that is~~] capable of reviewing the evidence of compliance of health care delivery [~~systems and their internal quality assurance mechanisms~~] and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [MAD-762], *Reproductive Health Services*).

(2) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an MCO, subcontractor, provider or member with the knowledge that the deception could result in some unauthorized benefit to himself or to some other previously described entity or person. It includes any act that constitutes fraud under applicable federal or state law.

(3) **Full risk contracts:** Contracts that place the MCO at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or MCO practices, either written, oral or implied, that effectively prevent a provider from furnishing accurate or complete information to members about options for diagnosis or treatment of physical, mental or behavioral illness, injury, or condition; or prevent a provider from talking to the member or HSD about the MCO or their business practices.

(2) **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO regarding utilization management decisions and/or provider payment issues.

(4) **Group of one:** Individuals who enroll without an employer group but report self-employment.

H. Definitions beginning with letter "H":

(1) **Health plan:** A health maintenance organization (HMO), managed care organization (MCO), or third party payer or their agents.

(2) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

(3) **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

(4) **Human services department (HSD):** The sole executive department in New Mexico responsible for the administration of SCI. "HSD" may also indicate the department's designee, as applicable.

I. Definitions beginning with letter "I":

(1) **Income groupings:** 0-100%, 101-150%, and 151-200% of federal poverty levels: These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

(2) **Incurred but not reported (IBNR):** Claims for services authorized or rendered for which the MCO has incurred financial liability, but the claim has not been received by the MCO. This estimating method relies on data from prior authorization and referral systems, [~~as well as~~] other data analysis systems and accepted accounting practices.

(3) **Individual:** A person who enrolls in SCI who is not a member of an eligible employer group and pays the premium amount designated for both the employee share, if applicable, based on income, and the employer share or has that amount paid on his behalf by another entity.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L": [RESERVED]

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

(2) **Marketing:** The act or process of promoting a business or commodity. Marketing includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO yellow page advertisements, and any other presentation materials used by an MCO, MCO representative, or MCO subcontractor to attract or retain SCI enrollment.

[~~(3) **MCO appeal (member):** A request from a member or a provider, with the member's written consent, for review by the managed care organization (MCO) of an MCO action. An "MCO appeal" should not be confused with an applicant's or recipient's right to appeal an HSD fair hearing decision to state district court under the Public Assistance Appeals Act, NMSA 1978, Section 27-3-4 and pursuant to NMSA 1978, Section 39-3-1.1.~~]

[~~(4)~~] (3) **Medicaid:** The medical assistance program authorized under Title XIX of the Social Security Act or its successors, furnished to New Mexico residents who meet specific eligibility requirements.

[~~(5)~~] (4) **Medically necessary services:**

(a) Medically necessary services are clinical and rehabilitative physical or behavioral health services that:

(i) are essential to prevent, diagnose or treat medical or behavioral health conditions or are essential to enable the individual to attain, maintain or regain functional capacity;

(ii) are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical and behavioral health care needs of the individual;

(iii) are provided within professionally accepted standards of practice and national guidelines; and

(iv) are required to meet the physical and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.

(b) Application of the definition:

(i) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit;

(ii) the MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the [~~medicaid~~] SCI benefit package applicable to an eligible individual shall do so by: 1) evaluating individual physical and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training, as appropriate; 2) considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and 3) considering the services being provided concurrently by other service delivery systems;

(iii) physical and behavioral health services shall not be denied solely because the individual has a poor prognosis; required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.

[~~(6)~~] (5) **Member:** A eligible member enrolled in an MCO.

[~~(7)~~] (6) **Member month:** A calendar month during which a member is enrolled in an MCO.

N. Definitions beginning with letter "N":

(1) **National committee for quality assurance (NCQA):** A private national organization that develops quality standards for managed health care.

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO to furnish physical or behavioral health services to the MCO's members under the provisions of the SCI managed care contract.

(3) **Notice:** A written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the circumstances under which the service may be continued if a hearing is requested.

O. Definitions beginning with letter "O": **Outreach:** The act or process of promoting an insurance product through established business channels of communications including brochures, leaflets, internet, print media, electronic media, signage or other materials used by MCOs to attract or retain SCI enrollment primarily through employer groups.

P. Definitions beginning with letter "P":

(1) **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

(2) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO to pend approval does not extend or modify required utilization management decision timelines.

(3) **Performance measurement (PM):** Data specified by the state that enables the MCO's performance to be determined.

(4) **Plan of care:** A written document including all medically necessary services to be provided by the MCO for a specific member.

(5) **Policy:** The statement or description of requirements.

(6) **Potential enrollee:** A Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

[~~(3)~~] (7) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

(8) **Preventative health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(4)~~] (9) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

(10) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

(11) **Procedure:** Process required to implement a policy.

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

(1) **Rate cell:** A combination of category of eligibility and demographics used to isolate utilization patterns for the determination of capitation.

(2) **Received but unpaid claims (RBUC):** Claims received by the MCO but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the MCO.

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service, based on the member's physical health, medical or behavioral health clinical need, than was originally requested, except pharmaceutical services which are covered by the formulary process.

(4) **Referral:** Any specialty, inpatient, outpatient, or diagnostic services that a physician or physician group orders or arranges, but does not provide directly.

(5) **Reinsurance:** Reinsurance is a proactive financial tool that may be used by an MCO to minimize exposure to losses incurred when members utilize health care services beyond anticipated levels or overall member utilization is greater than expected.

(6) **Risk:** The possibility that revenues of the MCO will not be sufficient to cover expenditures incurred in the delivery of contractual services.

(7) **Routine care:** All care, which is not emergent or urgent.

S. Definitions beginning with letter "S":

(1) **SCI (state coverage insurance):** The New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver granted to the state by the centers for medicare and medicaid services (CMS).

(2) **SCI members with special health care needs (SCI-SHCN):** Individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation and who also require health and related services of a type or amount beyond that required by individuals.

(3) **Single statewide entity (SE):** Refers to the entity selected by the state of New Mexico through the collaborative to perform all contract functions defined in the behavioral health request for proposal (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will receive delegation by the MCO for SCI managed care. The SE shall contract with the MCO and may be responsible for contracting with providers, paying provider claims, assuring care coordination, conducting utilization review and utilization management activities, assuring quality review and service delivery improvement, credentialing practitioners and provider agencies, privileging practitioners to deliver critical services or service approaches, evaluating and monitoring of service delivery and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate," "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico."

(4) **Subcontract:** A written agreement between the MCO and a third party, or between a subcontractor and another subcontractor, to provide services.

(5) **Subcontractor:** A third party who contracts with the MCO or an MCO subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary[~~, except pharmaceutical services, which are covered by the formulary process~~].

(2) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for SCI members for services furnished.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

V. Definitions beginning with the letter "V": **Value added benefit**: Any benefit offered to members by the MCO that is not included in the SCI benefit package.

[8.306.1.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 3 CONTRACT MANAGEMENT

8.306.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS: The human services department (HSD) shall award contracts to managed care organizations and other state entities that meet applicable requirements and standards under state and federal law, including Title [~~IV~~] VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act. Risk-based contracts will be awarded to MCOs with statutory authority to assume risk. The physical and behavioral health services to be delivered under the terms of the contract are defined in 8.306.7 NMAC, *Benefit Package*.
[8.306.3.9 NMAC - N, 7-1-05; A, 6-1-08]

8.306.3.10 CONTRACT MANAGEMENT:

A. **General contract requirements:** The MCOs shall meet all specified terms of the SCI contract and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO will be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD. HSD is responsible for management of the SCI managed care contracts issued to MCOs. HSD shall provide the oversight and administrative functions to ensure MCO compliance with the terms of the SCI managed care contract.

B. **Subcontracting requirements:** The MCO may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO function. The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO shall submit boilerplate contract language and sample contracts for various types of subcontracts. Any substantive changes to contract templates shall be approved by HSD prior to issuance.

(1) **Credentialing requirements:** The MCO shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards.

(2) **Review requirements:** The MCO shall maintain a fully executed original of all subcontracts and make them available to HSD on request.

(3) **Minimum requirements:** Subcontracts shall contain the following provisions:

(a) subcontracts shall be executed in accordance with applicable federal and state laws, regulations, policies and rules;

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis of operation in the state of New Mexico;

(c) subcontracts shall include procedures and criteria for terminating the subcontract;

(d) subcontracts shall identify the services to be performed by the subcontractor including a description of how members access services provided under the subcontract;

(e) subcontracts shall include reimbursement rates and risk assumption, where applicable;

(f) subcontractors shall maintain records relating to services provided to members for ten years;

(g) subcontracts shall require that member information be kept confidential, as defined by federal or state law and be HIPAA compliant;

(h) subcontracts shall provide that authorized representatives of HSD have reasonable access to facilities, personnel and records for financial and medical audit purposes;

(i) subcontracts shall provide for the subcontractor to release to the MCO any information necessary to perform any of its obligations;

(j) the subcontractor shall accept payment from the MCO for any services provided under the benefit package and may not request payment from HSD for services performed under the subcontract;

(k) if the subcontract includes primary care, the subcontractor shall comply with PCP requirements in the MCO contract with HSD;

(l) the subcontractor shall comply with all applicable state and federal statutes, rules and regulations, including prohibitions against discrimination;

(m) the subcontract shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO;

(n) the subcontract shall allow providers to assist members to access the grievance process or to act to protect member interests; [~~and~~]

(o) the subcontract shall specify the time frame for submission of encounter data to the MCO; [~~and~~]

[~~(p) subcontracts shall include detailed information regarding employee education of the New Mexico and federal False Claims Act.~~]

(p) subcontracts to entities that receive annual Medicaid payments of at least $5 million shall include detailed information regarding employee education of the New Mexico and federal False Claims Act; and

(q) subcontracts shall include a provision requiring subcontractors to perform criminal background checks for all required individuals providing services.

(4) **Excluded providers:** The MCO shall not contract with any individual provider, or entity, or entity with an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act; has been excluded from participation in any other state's medicaid , medicare, or any other public or private health or health insurance program; has been assessed a civil penalty under the provision of Section 1128; or who has had a contractual relationship with an entity or individual convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The MCO shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.

[8.306.3.10 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

8.306.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO shall provide the following information to HSD and updates, modifications, or amendments to HSD within thirty (30) days:

(1) current organization charts or other written plans identifying organizational lines of accountability;

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the
MCO's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and

(3) documents describing the MCO's relationship to parent-affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. [**~~Policies and procedures~~**] **Policies, procedures and job descriptions:** The MCO shall establish and maintain written policies, procedures and job descriptions as required by HSD. The MCO shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The MCO shall provide MCO policies, procedures, and job descriptions for key personnel and guidelines for review to HSD on request. The MCO shall notify HSD within thirty (30) days when changes occur in key personnel.

(1) **Review of policies and procedures:** The MCO shall review the MCO's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Substantive modification or amendment to key positions shall be reviewed by HSD.

(2) **Distribution of information:** The MCO shall distribute to providers information necessary to ensure that providers meet all contract requirements.

(3) **Business requirements:** The MCO shall have the administrative, information and other systems in place necessary to fulfill the terms of the SCI managed care contract. Any change in identified key MCO personnel shall conform to the requirements of the SCI managed care contract. The MCO shall

retain financial records, supporting documents, statistical records, and all other records for a period of three (3) years from the date of submission of the final expenditure report, except as specified by HSD.

(4) **Financial requirements:** The MCO shall meet the requirements of federal and state law with respect to solvency and performance guarantees for the duration of the SCI managed care contract. The MCO shall meet additional financial requirements specified in the SCI managed care contract.

(5) **Member services:** The MCO shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The MCO shall establish representation on its current medicaid managed care consumer advisory board that includes SCI. This representation may have regional representation of [~~customers~~] consumers, family members, advocates and providers who participate in SCI. The MCO can also devise a method, approved by HSD/MAD, to elicit feedback from SCI consumers and address their needs, if formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members.

(a) Consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to SCI.

(b) The MCO shall attend at least two statewide consumer-driven or hosted meetings, relevant to the SCI population, per year, of the MCO's choosing, that focus on consumer issues and needs to ensure that member's concerns are heard and addressed.

(7) **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose civil or administrative monetary penalties and fines under the following guidelines:

(i) a maximum of $25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;

(ii) a maximum of $100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD, or CMS;

(iii) a maximum of $15,000.00 for each SCI member that HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of $100,000.00;

(iv) a maximum of $25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the SCI program; the state shall deduct from the penalty the amount of overcharge and return it to the affected enrollee; and

(d) rescind marketing consent;

(e) suspend new enrollment, including default enrollment after the effective date of the sanction;

(f) appoint a state monitor, the cost of which shall be borne by the MCO;

(g) deny payment of capitation rates;

(h) assess actual damages;

(i) assess liquidated damages;

(j) remove members with third party coverage from enrollment with the MCO;

(k) allow members to terminate enrollment;

(l) suspend or terminate MCO contract;

(m) apply other sanctions and remedies specified by HSD; and

(n) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that;

(i) there is continued behavior by the MCO as described under sub-paragraph (c) above including but not limited to behavior that is prohibited under specific federal law granting states appropriations for medicaid services, 42 USC Sections 1396b(m) or 1396u-2; or

(ii) there is substantial risk to member's health; or

(iii) the sanction is necessary to ensure the health of the MCO's members while improvement is made to remedy violations made under Subparagraph (c) above; or until there is orderly termination or reorganization of the MCO; and

(iv) there shall be no provision for hearing prior to the imposition of temporary management and HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not re-occur.

[8.306.3.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 5 ENROLLMENT

8.306.5.14 SCI MARKETING-OUTREACH GUIDELINES: When marketing to SCI members, MCOs shall follow the SCI marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity. The marketing and outreach material shall meet the following minimum requirements:

(1) marketing and outreach materials shall meet requirements for all communication with SCI members, as required in the quality standards (8.305.8.15 NMAC, *Member Bill of Rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO under the SCI contract shall state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a population of greater than 5% in the MCO membership, as identified by the MCO and HSD, that has limited English proficiency, as identified by the MCO or HSD, marketing materials shall be available in the language of that population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets; newspaper, magazine, radio, television, billboard, and MCO yellow page advertisement, and web site and presentation materials used by an MCO and MCO representative or MCO sub-contractor to attract and retain SCI enrollment. HSD may request, review and approve or disapprove any communication to any SCI member. HSD may request, review and approve or disapprove any communication to any SCI member regarding behavioral health. MCOs are not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at SCI members and marketing material that mentions SCI, medicaid, medical assistance, Title XIX , Title XXI or Salud! or makes reference to medicaid behavioral health services. The MCO shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to SCI populations, such as billboards or bus posters disproportionately located in low-income neighborhoods; or

(2) contain language or information designed to attract SCI enrollment.

C. **Advertising and marketing material:** Medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the internet requires HSD approval. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material shall be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references:** Misleading information about the MCO shall not be allowed even if it is accurate.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO directly, its network providers, its subcontractors or any other party affiliated with the MCO. HSD may prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose SCI benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan that discourages or encourages MCO selection based on a potential member's health status or risk;

(3) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(4) asserting or implying that the MCO offers unique covered services when another MCO provides the same or similar services;

(5) the use of more than nominal gifts, such as diapers, toasters, infant formula or other incentives to entice members to join a specific health plan;

(6) telemarketing [~~or face-to-face~~] or other cold call marketing with potential members;

(7) conducting any other marketing activity prohibited by HSD;

(8) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(9) distributing any marketing materials without first obtaining HSD approval;

(10) seeking to influence enrollment in conjunction with the sale or offering of any private insurance;

(11) engaging in [~~door-to-door,~~] telephone or other cold call marketing activities, directly or indirectly; and

(12) other requirements specified by HSD.

E. **Marketing in current care sites:** Promotional materials may be made available to members and potential MCO enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings with MCO staff, at health care delivery sites, for the purpose of marketing to potential enrollees shall not be permitted.

F. **Provider communications with medicaid members about MCO options:** HSD marketing restrictions shall apply to MCO subcontractors and providers as well as to the MCO. MCOs are required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Member-initiated meetings with MCO staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site.

H. **Mailings by the MCO:** MCO mailings shall be permitted in response to member oral or written requests for information. The content of marketing or promotional mailings shall be approved by HSD. MCOs may, with HSD approval, provide potential members with information regarding the MCO/SCI benefit package. MCOs shall not send gifts, however nominal in value, in these mailings. MCOs may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be approved by HSD.

I. **Group meetings:** The MCO may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve marketing material to be presented at the meeting. HSD shall approve the methodology used by the MCO to solicit attendance for the public meetings. HSD may attend the meeting.

J. **Light refreshments for members at meetings:** The MCO may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to potential members:** MCOs and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs to include reward items in information sent to new MCO members.

M. **Marketing time frames:** The MCO may initiate marketing and outreach activities at any time.

[8.306.5.14 NMAC - N, 7-1-05; A/E, 8-1-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 6 PROVIDER NETWORKS

8.306.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) shall be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall distribute information to the providers explaining the SCI-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

(2) coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy;

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services;

(4) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations;

(5) ensuring the member receives appropriate prevention services for his age group;

(6) following MCO established procedures for coordination of services for members with providers participating in the MCO network; and

(7) the MCO shall develop and implement policies and procedures governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed.

B. **Types of primary care providers:** The MCO may designate the following providers as PCPs, as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, and gynecology;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individualized basis for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or a disability;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that includes certified mid-level practitioners who, at the member’s request, may serve as
the point of first contact; in both instances, the MCO shall organize its teams to ensure continuity of care to members and shall identify a “lead physician” within the team for each member; the “lead physician” shall be an attending physician (medical students, interns and residents cannot serve as the “lead physician”); or

(5) other providers who meet the MCO credentialing requirements as a PCP.

C. **Providers that shall not be excluded as PCPs:** MCOs shall not exclude providers as primary care providers based on the proportion of high-risk patients in their caseloads.

D. **Selection or assignment to a PCP:** The MCO shall maintain written policies and procedures governing the process of member selection of a PCP and requests for a change in PCP.

(1) **Initial enrollment:** At the time of enrollment into the MCO, the MCO shall ensure that each member may choose a PCP within a reasonable distance from the member’s residence.

(a) The MCO shall assume responsibility for assisting members with PCP selection.

(b) The process whereby the MCO assigns members to PCPs shall include at least the following features:

(i) the MCO shall contact the member within five business days of enrollment and provide information on options for selecting a PCP;

(ii) the MCO shall offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP or the MCO will assign a PCP within 15 calendar days of enrollment with the MCO; a member may select a PCP from the information provided by the MCO; a member may choose a PCP anytime during this selection period;

(iv) the MCO shall notify the member in writing of his PCP's name, location and office telephone number; and

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request.

(3) **Subsequent change in PCP initiated by the MCO:** In instances where a PCP has been terminated, the MCO shall allow affected members to select another PCP or make an assignment within 15 days of the termination effective date. The MCO shall notify the member in writing of the PCP's name, location and office telephone number. The MCO may initiate a PCP change for a member under certain circumstances such as:

(a) the member and MCO agree that assignment to a different PCP in the MCO is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the MCO's network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal action against the PCP.

(4) **Provider lock-in:** HSD [~~MCOs~~] shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or a member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on provider lock-in, the MCO shall inform the member of the intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins on a quarterly basis and informed of provider lock-in removals at the time they occur.

E. **MCO responsibility for PCP services:** The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.

[8.306.6.12 NMAC - N, 7-1-05; A, 6-1-08]

8.306.6.17 MCO PROVIDER TRANSITION OF CARE: The MCO shall notify HSD of unexpected changes to the composition of its provider network that would have a significantly negative effect on member access to services or on the MCO's ability to deliver services included in the benefit package in a timely manner. In the event that provider network changes are unexpected or when it is determined that a provider is unable to meet their contractual obligation, the MCO shall be required to submit a transition plan(s) to HSD for all affected members.

[8.306.6 NMAC – N, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 7 BENEFIT PACKAGE

8.306.7.9 BENEFIT PACKAGE: This part defines the state coverage insurance (SCI) benefit package for which the MCO will be paid fixed payment rates. The MCO shall cover these services. The MCO shall not delete benefits from the SCI-defined benefit package. An MCO is encouraged to provide [~~an enhanced~~] a value added benefit package, which could include health-related educational, preventive, outreach and [~~enhanced~~] value added physical and behavioral health [~~services~~] benefits. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services.
[8.306.7.9 NMAC - N, 7-1-05; A, 6-1-08]

8.306.7.11 SERVICES INCLUDED IN THE SCI BENEFIT PACKAGE: The SCI benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are provided by or under the direction of the member's PCP. The following lists covered services and provides additional information.

A. **Provider services**:
(1) office visits;
(2) home visits;
(3) hospital and inpatient physical rehabilitation facility visits by physician;
(4) inpatient and outpatient surgery (includes assistant surgeon's charges);
(5) office procedures;
(6) inpatient professional care services, including pathologists, radiologists and anesthesiologists;
(7) allergy testing;
(8) allergy injections;
(9) antigen serum;
(10) injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office;
(11) injections in accordance with acceptable medical practice used to treat chronic conditions, including, but not limited to, diseases such as rheumatoid arthritis, crohn's disease, and hepatitis C; and
(12) routine and diagnostic x-rays and clinical laboratory tests.

B. **Inpatient hospital services:** The benefit package includes inpatient hospital services as detailed below.
(1) Hospital admissions must have prior authorization and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.
(2) Inpatient hospitalization coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with home health services and inpatient physical rehabilitation.
(3) Inpatient hospital services include:
(a) semi-private room and board accommodations, including general duty nursing care;
(b) private room and board accommodations when medically necessary; prior authorization is required;
(c) in-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units;
(d) use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;
(e) laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital;
(f) anesthetics, oxygen, pharmaceuticals, medications, and other biological;
(g) dressings, casts, and special equipment when supplied by the hospital for use in the hospital;
(h) inpatient meals and special diets;
(i) inpatient radiation therapy and/or inhalation therapy;
(j) rehabilitative services - physical, occupational, and speech therapy;

(k) administration of whole blood, blood plasma, and components;
(l) discharge planning and coordination of services; and
(m) maternity care.

C. **Outpatient services:** The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

(1) can reasonably be provided on an ambulatory basis;
(2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;
(3) require prior authorization, unless otherwise noted; and
(4) the following provides additional information on covered outpatient services and associated co-payments:

(a) surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies, including anesthesia, dressings and medications;
(b) radiation therapy and chemotherapy;
(c) magnetic resonance imaging (MRI);
(d) positron emission tomography (PET) tests;
(e) CT scan;
(f) holter monitors and cardiac event monitors;
(g) routine and diagnostic x-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs);
(h) cardiovascular rehabilitation; and
(i) rehabilitative services - physical, occupational, and speech therapy; rehabilitative services for short-term physical, occupational, and speech therapies are covered; short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment; the member's PCP or other appropriate treating provider to whom the member has been referred shall determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months; requests for rehabilitative services from therapists will not be approved; these services shall be requested by the ordering provider and require a prior authorization.

[~~(i)~~] (ii) Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, contingent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two-month period as documented in the therapy record.

[~~(ii)~~] (iii) Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.

D. **Emergency and urgently needed health services:** The benefit package includes emergency and urgently needed health services. These services are available twenty-four (24) hours a day, seven (7) days a week. The benefit package includes inpatient and outpatient services meeting the definition of emergency services, which shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain the stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or
(2) the hospital contacted the MCO but did not get instructions within an hour of the request; the following provides additional information on covered services and required co-payments.

(a) Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols.

(i) Prior authorization is not required for emergency care.

(ii) Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as soon as it is medically appropriate. Such members shall be stabilized and the transfer effected in accordance with federal law.

(iii) The member is responsible for charges for non-covered services.

(b) Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member if such services were not received immediately.

(i) A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider.

(ii) Routine or follow-up medical treatment shall be provided by or through a participating provider.

E. **Women's health services:** The benefit package includes any gynecological examinations or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following lists covered services and provides additional information:

(1) office visits;

(2) low-dose mammography screening for detection of breast cancer;

(3) cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems; and

(4) services related to the diagnosis, treatment and appropriate management of osteoporosis.

F. **Prenatal and post-partum care:** Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two (2) office visits per month during the seventh and eight months of pregnancy; and one (1) office visit per week during the ninth month until tremor as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education.

(1) Following delivery of a newborn, a female member is entitled to either:

(a) post-partum care in the home consisting of up to three visits; or

(b) a minimum hospital stay of specified inpatient hours; the choice of either home care or inpatient care will be made based on discussion between the participating provider and the member.

(2) If post-partum home care is elected, the care shall be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider who is properly licensed, trained and experienced. A maximum of three home care visits are allowable.

(3) If inpatient care is elected, a mother and her newborn child in a health care facility will be entitled to a minimum stay of 48 hours following a vaginal delivery or 96 hours following a caesarian section.

(4) Non- hospital births - prior authorization is required.

G. **Preventive health services:** The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to whom the member has been referred by his PCP, and are consistent with the MCO'S preventive health guidelines. The following lists covered services and provides additional information.

(1) Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures.

(2) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level.

(3) Periodic glaucoma eye tests for all persons thirty-five (35) years of age and older.

(4) Periodic stool examination for the presence of blood for all persons 40 years of age or older.

(5) Periodic mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram biennially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.

(6) All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. The consultation may include, but not be limited to:

(a) smoking control;
(b) nutrition and diet recommendations;
(c) exercise plans;
(d) lower back protection;
(e) immunization practices;
(f) breast self-examinations;
(g) testicular self-examinations; or
(h) use of seat belts in motor vehicles.

(7) Adult immunizations in accordance with the recommendations of the advisory committee on immunization practices (ACIP).

(8) Periodic colon examination of thirty-five (35) to sixty (60) centimeters and/or barium enema for all persons forty-five (45) years of age or older.

(9) Voluntary family planning services.

(10) Insertion of contraceptive devices.

(11) Removal of contraceptive devices.

(12) Surgical sterilization.

(13) Pregnancy termination procedures: The benefit package includes services for the termination of pregnancy and pre or post-decision counseling or psychological services as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures.*

H. **Dialysis:** The benefit package includes dialysis services. Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member shall advise the MCO of the date the treatment commenced.

I. **Inpatient physical rehabilitation:** The benefit package includes inpatient physical rehabilitation. The following lists covered services and provides additional information.

(1) Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Inpatient physical rehabilitation facility coverage is limited to twenty-five (25) days per benefit year. This twenty-five (25)-day limitation is combined with inpatient hospital and home health services.

J. **Home health services/home intravenous services:** The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The following lists covered services and provides additional information.

(1) Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Home health services in lieu of hospitalization are limited to twenty-five (25) days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This twenty-five (25) day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.

(3) Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; or by a home health aide are covered.

(4) Prescription supplies for the provision of home health services at the time of a home health visit are covered.

(5) Home intravenous services are covered.

(6) Tube feedings as the sole source of nutrition are covered.

K. **Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices:** The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The following lists covered services and provides additional information.

(1) Prior authorization is required.

(2) Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of $200 or more per item, including tax and any shipping charges are covered. Rental price cannot exceed purchase price.

(3) Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded.

(4) Medical supplies that require a provider's prescription for purchase are covered unless otherwise excluded.

(5) Orthotic appliances that require a provider's prescription for purchase are covered unless otherwise excluded.

(6) Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement, unless otherwise excluded.

(7) Breast prostheses and bras required in conjunction with reconstructive surgery are covered, except as limited.

(8) Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear and/or when necessitated by the body's growth or atrophy are covered.

L. **Ambulance services:** The benefit package includes emergency transport services identified below.

(1) When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

(2) The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

(3) Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service

(4) Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible.

M. **Oral surgery:** The benefit package includes limited oral surgery benefits with prior authorization. The following lists covered services and provides additional information. General dental and oral surgery services with a prior authorization only in conjunction with:

(1) Accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within seventy-two (72) hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within twelve (12) months of the date of injury. The MCO will require dental x-rays.

(2) Surgical procedures to correct non-dental, non-maxillomandibular physiologic conditions that produce demonstrable impairment of function are covered.

(3) Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered.

(4) External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; and removal of stones from salivary ducts are covered.

(5) Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth are covered.

N. **Reconstructive surgery:** The benefit package includes reconstructive surgery as provided below.

(1) Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders - prior authorization is required. Functional disorder shall result from accidental injury or from congenital defects or disease.

(2) Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications at all stages of mastectomy, including lymph edemas. A member is allowed at least forty-eight (48) hours of inpatient care following mastectomy and twenty four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

O. **Prescription drugs:** The benefit package includes all generic prescription drugs and brand name drugs included on the MCO'S preferred drug list (PDL). Exceptions to the PDL depend on MCO policy.

P. **Diabetes treatment:** The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide resources to members with diabetes; and guarantee reimbursement or coverage for prescription drugs, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following lists covered services and provides additional information.

(1) Equipment, supplies and appliances to treat diabetes to include:

(a) blood glucose monitors, including those for the legally blind;
(b) test strips for blood glucose monitors;
(c) visual reading urine and ketone strips;
(d) lancets and lancet devices;
(e) insulin (limit two (2) vials per co-payment);
(f) injection aids, including those adaptable to meet the needs of the legally blind;
(g) syringes;
(h) prescriptive oral agents for controlling blood sugar levels;
(i) medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and
(j) glucagons emergency kits.

(2) Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to:
(a) medically necessary visits upon the diagnosis of diabetes;
(b) visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management;
(c) visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and
(d) medical nutrition therapy related to diabetes management.

Q. **Behavioral health and substance abuse services:** The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to twenty-five (25) days per benefit year with prior authorization.

(1) **Behavioral health service:**
(a) Outpatient office visits for mental health evaluation and treatment; injectable forms of haloperidol or fluphenazine are included in the office visit co-payment. Prior authorization is required for over seven (7) visits.
(b) Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - *prior authorization is required*.

(2) **Substance abuse service:**
(a) outpatient substance abuse including visits, detoxification and intensive outpatient care limited to forty two (42) days per benefit year; and
(b) inpatient substance abuse detoxification - *prior authorization is required.*

R. **Annual limits on out-of-pocket expenditures:** Out-of-pocket charges for all participants will be limited to 5 percent of maximum gross family income per benefit year. Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.

S. **Limitations on coverage:** The benefit package is limited to $100,000 in benefits payable per member per benefit year.

T. **Pregnancy termination procedures:** The MCO shall provide coverage of pregnancy termination as allowed per 42 CFR 457.475. [~~A certification from the provider must be provided to the MCO.~~] Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 457.475 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC.

[8.306.7.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 12 MEMBER GRIEVANCE RESOLUTION

8.306.12 MEMBER GRIEVANCE RESOLUTION

8.306.12.9 ~~[GRIEVANCE SYSTEM:~~

~~A. The MCO shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to an MCO action, including the opportunity to request an HSD fair hearing.~~

~~B. A grievance is a member's expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action, as defined below.~~

~~C. An appeal is a request for review by the MCO of an MCO action. An 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; or the failure to provide services in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.~~

~~D. The member, legal guardian of the member for minors or incapacitated adults, or a representative of the member as designated in writing to the MCO, has the right to file a grievance or an appeal of the MCO action on behalf of the member. A provider acting on behalf of the member and with the member's written consent may file a grievance and/or an appeal of an MCO action.~~

~~E. In addition to the MCO grievance and appeal process described above, a member, legal guardian of the member for an incapacitated adult, or the representative of the member has the right to request a fair hearing on behalf of the member with HSD directly as described in 8.352.2 NMAC, *Fair Hearings*, if an MCO decision results in termination, modification, suspension, reduction, or denial of services to the member or if the member believes the MCO has taken an action erroneously. A fair hearing may be requested only after the MCO grievance/appeal process has been exhausted. Issues of late premium payment or failure to pay the premium addressed through the MCO grievance and appeal process and not resolved at that level must next be taken to judicial appeal in the state district court at the appellant's expense.~~ [RESERVED]

[8.306.12.9 NMAC - N, 7-1-05; A, 6-1-08]

8.306.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

A. The MCO shall have a grievance system in place for members that includes a grievance process related to dissatisfaction, and an appeals process related to an MCO action, including the opportunity to request an HSD fair hearing.

B. A fair hearing may be requested only after the MCO grievance/appeal process has been exhausted. Issues of late premium payment or failure to pay the premium addressed through the MCO grievance and appeal process and not resolved at that level must next be taken to judicial appeal in the state district court at the appellant's expense.

[~~A.~~] (C.) The MCO shall implement written policies and procedures describing how the member may register a grievance or an appeal with the MCO or register a request for a fair hearing with HSD. The policy should include a description of how the MCO resolves the grievance or appeal.

[~~B~~] (D.) The MCO shall provide to all service providers in the MCO's network a written description of the MCO's grievance and appeal process and how the provider can submit a grievance and/or appeal.

[~~C~~] (E.) The MCO shall 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 capability.

[~~D~~] (F.) The MCO shall name a specific individual(s) designated as the MCO's medicaid member grievance and/or appeal coordinator with the authority to administer the policies and procedures for resolution of a grievance and/or an appeal, to review patterns/trends in grievances and/or appeals, and to initiate corrective action.

[~~E~~] (G.) The MCO shall ensure that the individuals who make decisions on grievances and/or appeals are not involved in any previous level of review or decision making. The MCO shall also ensure that health care professionals with appropriate clinical expertise will make decisions for the following:

(1) an appeal of an MCO denial that is based on lack of medical necessity;
(2) an MCO denial that is upheld in an expedited resolution;
(3) a grievance or appeal that involves clinical issues.

[~~F~~] (H.) Upon enrollment, the MCO shall provide members, at no cost, with a member information sheet or handbook that provides information on how they and/or their representative(s) can file a grievance and/or an appeal, and the resolution process. The member information shall also advise members of their right to file a request for an administrative hearing with the HSD hearings bureau following an appeal of the MCO action. The information shall meet the standards for communication specified in 8.305.8.15 NMAC.

[~~G~~] (I.) The MCO must ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance and/or an appeal, or a provider that supports a member's grievance and/or appeal.
[8.306.12.10 NMAC - N, 7-1-05; A, 6-1-08]

8.306.12.11 GRIEVANCE: A grievance is [~~a member's~~] an expression of dissatisfaction about any matter or aspect of the MCO or its operation other than an MCO action.

A. A member may file a grievance either orally or in writing with the MCO within 90 calendar days of the date of the event causing the dissatisfaction [~~occurred~~]. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, and a provider acting on behalf of the member and with the member's written consent, have the right to file a grievance on behalf of the member.

B. Within five (5) working days of receipt of the grievance, the MCO shall provide the grievant with written notice that the grievance has been received and the expected date of its resolution.

C. The investigation and final MCO resolution process for grievances shall be completed within thirty (30) calendar days of the date the grievance is received by the MCO and shall include a resolution letter to the grievant.

D. The MCO may request an extension from HSD of up to fourteen (14) calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the extension within two (2) working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the MCO shall mail a resolution letter to the member. The resolution letter must include, but not be limited to, the following:

(1) all information considered in investigating the grievance;
(2) findings and conclusions based on the investigation; and
(3) the disposition of the grievance.

[8.306.12.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

8.306.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;
(3) the denial, in whole or in part, of payment for a service;
(4) the failure of the MCO to provide services in a timely manner, as defined by HSD; or
(5) the failure of the MCO to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member and/or provider within 10 days of the date of an action [~~except for denial~~] for previously authorized services as permitted under 42 CFR 431.213 and 431.214 and within 14 days of the action for newly requested services. Denials of claims which may result in member financial liability [~~which requires~~] require immediate notification. The notice must contain but not be limited to the following:
(1) the action the MCO has taken or intends to take;
(2) the reasons for the action;
(3) the member's or the provider's right, as applicable, to file an appeal of the MCO action through the MCO;
(4) the member's right to request an HSD fair hearing and what the 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) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative or estate representative of a deceased member as parties to the appeal.

D. The MCO has 30 calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal. The MCO shall appoint at least one person to review the appeal who was not involved in the initial decision and who is not the subordinate of any person involved in the initial decision.

E. The MCO shall have a process in place that that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO will make best efforts to assist members as needed with the written appeal.

F. Within five working days of receipt of the appeal, the MCO shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO may extend the 30 day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

H. The MCO shall provide the member and/or the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

I. The MCO shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

J. For all appeals, the MCO shall provide written notice within the 30-calendar day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.
(1) The written notice of the appeal resolution must include, but not be limited to, the following information:
(a) the result(s) of the appeal resolution; and
(b) the date it was completed.
(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:
(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

K. The MCO may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO/SE action and/or asks for a fair hearing within 13 days from the date on the MCO/SE notice of action;

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The MCO shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) [~~ten~~] thirteen (13) days have passed since the date of the [~~MCO mailed the~~] resolution letter, [~~providing~~] provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO's[~~/SE's~~] action is upheld, the MCO may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy in 42 CFR Section 431.230(b).

(4) If the MCO or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO must pay for these services.

(6) If HSD reverses a decision to deny eligibility, the potential member can enroll with the MCO, but there will be no retroactive enrollment or benefit coverage under such circumstances.

[8.306.12.12 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

8.306.12.13 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the MCO of an MCO action.

A. The MCO shall establish and maintain an expedited review process for appeals when the MCO determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Such a determination is based on:

(1) a request from the member;

(2) a provider's support of the member's request;

(3) a provider's request on behalf of the member; or

(4) the MCO's independent determination.

B. The MCO shall ensure that the expedited review process is convenient and efficient for the member.

C. The MCO shall resolve the appeal within 3 working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited. In addition to written resolution notice, the MCO/SE shall also make reasonable efforts to provide and document oral notice.

D. The MCO may extend the timeframe by up to 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information and the extension is in the member's interest. For any extension not requested by the member, the MCO shall give the member written notice of the reason for the delay.

E. The MCO shall ensure that punitive action is not taken against a member or a provider who requests an expedited resolution or supports a member's expedited appeal.

F. The MCO shall provide expedited resolution if the request meets the definition of an expedited appeal in response to an oral or written request from the member or provider on behalf of the member.

G. The MCO shall inform the member of the limited time available to present evidence and allegations in fact or law.

H. If the MCO denies a request for an expedited resolution of an appeal, it shall:

(1) transfer the appeal to the 30 day timeframe for standard resolution, in which the thirty (30)-day period begins on the date the MCO received the request; and

(2) make reasonable efforts to give the member prompt oral notice of the denial, and follow up with a written notice within 2 calendar days[~~; and~~].

[~~(3) inform the member in the written notice of the right to file an appeal and/or request an HSD fair hearing if the member is dissatisfied with the MCO's decision to deny an expedited resolution.~~]

I. The MCO shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.

[8.306.12.13 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 13 FRAUD AND ABUSE

8.306.13.10 MANAGED CARE ORGANIZATION REQUIREMENTS: The MCO shall have in place internal controls and policies and procedures that are capable of preventing, detecting, investigating and reporting potential fraud and abuse activities concerning both providers and/or members. The MCO specific internal controls and policies and procedures shall be described in a comprehensive written plan submitted to HSD or its designee for approval. Substantive amendments or modifications to the policies and procedures shall be approved by HSD.[~~, or its designee. At a minimum, the written plan shall include~~] The MCO shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The MCO shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD or its designee for further investigation;

B. [~~a description of the~~] have specific controls in place for prevention and detection of potential cases of fraud and abuse such as: claims edits, post processing review of claims, provider [~~profiling~~] profiling/exception reporting and credentialing; prior authorizations, utilization /quality management monitoring;

C. have a mechanism to work with HSD or its designee to further develop prevention and detection mechanisms and best practices and to monitor outcomes for SCI;

D. have internal procedures to prevent, detect and investigate program violations to [~~help~~] recover funds misspent due to fraudulent or abusive actions; [~~and~~]

E. [~~the requirements to~~] report to HSD the names of all providers identified with aberrant utilization according to provider profiles, regardless of the cause of aberrancy[~~.~~];

F. designate a compliance officer and a compliance committee who are accountable to senior management; and

G. provide effective fraud and abuse detection training, administrative remedies for false claims and statements and whistleblower protection under such laws to the MCO's employees that include:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs (as defined in section 1128B (f) of the Social Security Act);

(2) as part of such written policies, detailed provision regarding the MCO's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) in any employee handbook, a specific discussion of the laws described in subparagraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's of subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse.

H. implement effective lines of communication between the compliance officer and the MCO's employees;

I. require enforcement of standards through well-publicized disciplinary guidelines; and

J. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO's contract.

[8.306.13.10 NMAC - N, 7-1-05; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 15 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS

8.306.15.9 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS (SCI-SHCN):

A. SCI-SHCN require a broad range of primary, specialized medical, behavioral health and related services. SCI-SHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, or low to severe functional limitation and who also require health and related services of a type or amount beyond that required by other individuals. SCI-SHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled SCI-SHCN:** The MCO shall have written policies and procedures in place with HSD approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCOs shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify SCI-SHCNs. The MCO shall employ reasonable effort to identify SCI-SHCNs based at least on the following criteria:

(1) individuals eligible for SSI;
(2) individuals identified by service utilization, clinical assessment, or diagnosis; and
(3) referral by family or a public or community program

[8.306.15.9 NMAC - N, 7-1-05; A, 6-1-08]

8.306.15.10 SCI ENROLLMENT FOR SCI-SHCN:

A. **Switch enrollment:** The MCO shall have policies and procedures to facilitate a smooth transition of a member who switches enrollment to another MCO. See Subsection E of 8.306.5.9 NMAC, *Member Switch Enrollment*. Individual members (not enrolled in an employer group), including SCI-SHCN, may request to break a lock-in and be switched to membership in another MCO, based on cause. The member, the member's family or legal guardian shall contact HSD to request that the member be switched to another MCO. [~~The MCO shall have policies and procedures to facilitate a smooth transition of a member who switches enrollment to another MCO. See Subsection E of 8.306.5.9 NMAC, *Member Switch Enrollment*.~~]

B. **SCI-SHCN information and education:**

(1) The MCO shall develop and distribute to SCI-SHCN members, caregivers, parents and/or legal guardians, as appropriate, information and materials specific to the needs of this population. This includes information, such as items and services that are provided or not provided by the SCI program, information about how to arrange transportation, and which services require a referral from the PCP. The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for care in an emergency room that is unfamiliar with the individual's special health care needs and about the availability of care coordination. See 8.306.9 NMAC, *Coordination Of Benefits*. This information may be included either in a special member handbook or in a SCI-SHCN insert to the MCO member handbook.

(2) The MCO shall provide health education information to assist a SCI-SCHN and/or caregivers in understanding how to cope with the day-to-day stress caused by chronic illness, including chronic behavioral health conditions.

(3) The MCO shall provide SCI-SHCNs and/or caregivers a list of key MCO resource people and their telephone numbers. The MCO shall designate a single point of contact that a SCI-SHCN, family member, caregiver, or provider may call for information.

[8.306.15.10 NMAC - N, 7-1-05; A, 6-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 16 [~~CLIENT~~] MEMBER TRANSITION OF CARE

8.306.16.9 [~~CLIENT~~] MEMBER TRANSITION OF CARE: The MCO shall have the resources and policies and procedures in place to ensure continuity of care without disruption in service to members and to assure the service provider of payment. The MCO shall actively assist with transition of care issues. During the individual member's SCI recertification of eligibility period and re-enrollment, the member may switch enrollment to a different MCO. Employer groups may also switch MCOs during the group re-enrollment process. Certain members may lose their SCI eligibility while enrolled in an MCO. A member changing from one MCO to another SCI MCO shall continue to receive medically necessary services in an uninterrupted manner. [~~The MCO shall have the resources and policies and procedures in place to ensure continuity of care without disruption in service to members and to assure the service provider of payment.~~]

A. **Member transition:** The MCO shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO, including the CLTS program.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member education about the MCO and the review and update of existing treatment plans.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment.

B. **Special payment requirement.** The MCO shall be responsible for payment of covered medical services, provided to the member for any month the MCO receives a capitation payment, even if the member has lost SCI eligibility.

C. Tracking of members who are nearing the annual claims benefit maximum or annual bed-day maximum.

(1) MCOs will track dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify individuals who are at [~~85~~] 50% of claims benefits paid out in a benefit year and those who have utilized 80% of their available hospital inpatient resources.

(2) Identified members who are at the [~~85~~] 50% level of claims payments or at 80% of hospital days available will have all care coordinated by the MCO to identify methods to manage care so as to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims and/or hospital day maximum.

(3) MCO will provide information on these individuals to HSD who will work in conjunction with the MCO to find alternative health care options for these individuals.

D. **Claims processing and payment:** In the event that an MCO's contract with HSD has ended, is not renewed or is terminated, the CONTRACTOR shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's contract has ended.

(1) The MCO shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO shall continue to meet timeframes established for processing all claims.

[8.306.16.9 NMAC - N, 7-1-05; A, 6-1-08]