State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
COORDINATED LONG-TERM SERVICES

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY

The Human Services Department Medical Assistance Division (HSD/MAD) proposes to implement a coordinated program of physical health and community-based supports and services, to be known as Coordinated Long-Term Services (CLTS). The program will be implemented under the authority of concurrent Section 1915(b) and Section 1915(c) waivers. HSD/MAD anticipates serving approximately 38,000 eligible individuals when CLTS program is implemented fully. Populations that will be included in the CLTS program are:

- Individuals eligible for both Medicare and Medicaid, but not requiring nursing facility level of care; and
- Individuals currently eligible for long-term care services based on assessed need for nursing facility level of care, including:
  - Nursing facility residents;
  - Participants in New Mexico's Disabled and Elderly (D&E) home and community-based services waiver program;
  - Individuals 21 years of age and older who are receiving Medicaid state plan Personal Care Option (PCO) services; and
  - Certain Medicaid-eligible persons with brain injuries.

Individuals who meet eligibility criteria set forth in New Mexico's 1915(c) Developmental Disabilities waiver and/or 1915(c) Medically Fragile waiver programs are not eligible for enrollment into the CLTS program.

The development and implementation of CLTS has been and will continue to be a collaborative effort among HSD/MAD, the Aging and Long-Term Services Department (ALTSD), and other key stakeholders. Working together, these agencies and stakeholders intend to:

- Rebalance Medicaid long-term supports and services from a heavy reliance on nursing facility services to expanded utilization of community-based supports and services;
- Improve and expand coordination of acute care and community-based supports and services for all consumers and participants; and
- Establish a consumer/participant-focused and directed "continuum of services" approach across each consumer's/participant's lifespan, with the goal of improving the consumer'/participant's health status and quality of life.

VI. REGULATIONS

These proposed regulation changes refer to 8.307 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/registers/. 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 August 1, 2008.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed regulations will be held at 1:00 p.m., on June 13, 2008, in the Rio Grande Room of the Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, New Mexico.

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 June 13, 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 307 COORDINATED LONG-TERM SERVICES
PART 1 GENERAL PROVISIONS

8.307.1.1 ISSUING AGENCY: Human Services Department
[8.307.1.1 NMAC – N, 8-1-08]

8.307.1.2 SCOPE: This rule applies to the general public.
[8.307.1.2 NMAC – N, 8-1-08]

8.307.1.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.1.3 NMAC - N, 8-1-08]

8.307.1.4 DURATION: Permanent
[8.307.1.4 NMAC – N, 8-1-08]

8.307.1.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.1.5 NMAC – N, 8-1-08]

8.307.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.1.6 NMAC – N, 8-1-08]

8.307.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a coordinated long-term services program has been implemented. This section contains the glossary for the New Mexico medicaid coordinated long-term services 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 medicaid, or the interagency behavioral health purchasing collaborative (the collaborative), 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 client or member practices that result in unnecessary costs to medicaid or the collaborative.

(2) **Action:** 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.

(3) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 §28-17-3

(4) **Advance directive:** Written instructions relating to the provision of health services when an adult is incapacitated. May include an advance directive, mental health advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive. See generally NMSA 1978 §§27-7A-1 to 27-7A-18 and §§24-7B-1 to 27-7B-16.

(5) **Adverse determination:** A determination by the coordinated long-term services managed care organization (CLTS MCO)/single statewide entity (SE), or by its utilization review agent, that the health care services furnished or proposed to be furnished to a member are not medically necessary or are not appropriate.

(6) **ALTSD:** The New Mexico aging and long-term services department.

(7) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the coordinated long-term services managed care organization (CLTS MCO) or the single statewide entity (SE) for behavioral health of a CLTS MCO/SE action as defined above in Paragraph (2) of Subsection A of 8.307.1.7 NMAC.

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

(9) **Approvals:** Approvals are either initial or concurrent review decisions, which yield utilization management authorizations based on the client meeting the clinical criteria for the requested medicaid service(s) or level of care.

(10) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select a CLTS MCO.

(11) **Assisted living services:** Residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health regulations 7.8.2 NMAC, *Residential Health Facilities*.

(12) **At risk:** The period of time that a member is enrolled with a CLTS MCO/SE, during which the CLTS MCO/SE is responsible for providing covered services under capitation.

B. Definitions beginning with letter "B":

(1) **Begin date:** The first day of the first full month following selection of or assignment to a CLTS MCO/SE.

(2) **Behavioral health:** Refers to mental health and substance abuse.

(3) **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 behavioral health service delivery in New Mexico. The SE will be expected to interact with the BHPC as an advisory council

(4) **Behavioral health purchasing collaborative:** Refers 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 eight agencies that provide and fund direct services, including the human services department.

(5) **Benefit package:** Medicaid covered services that must be furnished by the CLTS MCO/SE, and for which payment is included in the capitation rate.

C. Definitions beginning with letter "C":

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

(2) **Case:** A household that medicaid treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(3) **Case management for physical health:** The targeted case management programs that are part of the medicaid benefit package. Targeted case management programs will continue to be important service components. In these programs, case managers typically function independently and assess a member's/family's needs and strengths; develop a service/treatment plan; and coordinate, advocate for and link members to all needed services related to the targeted case management program.

(4) **Claim:** A bill for services, a line item of service, or all services for one member within a bill.

(5) **Claim dispute:** A dispute, filed by a CLTS MCO/SE or a service provider, involving payment of a claim, denial of a claim, or imposition of a sanction.

(6) **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. 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.

(7) **Client:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "client" may also be referred to as a "member", "customer", or "consumer".

(8) **CLTS MCO/SE:** The use of CLTS MCO/SE in these coordinated long-term services regulations indicates the following regulation applies to both the CLTS MCO and the SE, who must each comply with the regulation independent of each other.

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

(10) **Community-based care:** A system of care that seeks to provide services to the greatest extent possible in or near the member's home community.

(11) **Complaint:** An expression of dissatisfaction expressed by a complainant, orally or in writing, to the CLTS MCO/SE or to HSD or its designee about any matter related to the CLTS MCO/SE other than an action.

Possible subjects for complaints include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a service provider or employee; or failure to respect a member's rights.

(12) **Comprehensive community support services (CCSS):** These services are goal-directed mental health rehabilitation services and supports for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.

(13) **Concurrent review:** A process of updating clinical information from a service provider to a CLTS MCO/SE regarding a member who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

(14) **Consumer:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "consumer" may also be referred to as a "member", "customer", "consumer", "participant", "client", or "recipient".

(15) **Member direction:** The ability of a member to be actively involved in and in control of, to the extent possible, all aspects of the member's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(16) **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 modifications of improvements, as indicated.

(17) **Coordinated long-term services:** 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.

(18) **Copayment:** A monetary amount specified by the state that the member pays directly to the CLTS MCO/SE or to a service provider at the time that covered services are rendered.

(19) **Critical incident:** A reportable incident that may include, but is not limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, medicaid state plan, and home and community-based services.

(20) **Cultural competence:** 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 to increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which a CLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The CLTS MCO/SE 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 medicaid, not being on the CLTS MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the CLTS MCO/SE or the medical assistance division.

. (3) **Denial, clinical:** A non-authorization decision at the time of an initial request for a medicaid service or a formulary exception request based on the member not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the client'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 processes, collaborative practice models, patient self-management education processes, evidence-based practice guidelines, process and outcome measurements, and internal quality improvement processes.

(5) **Disenrollment, CLTS MCO initiated:** When requested by a CLTS MCO for substantial reason, removal of a medicaid member from membership in the requesting CLTS MCO, as determined by HSD, on a case-by-case basis.

(6) **Disenrollment, member initiated (switch):** When requested by a member for substantial reason, transfer of a medicaid member as determined by HSD on a case-by-case basis, from one CLTS MCO to a different

CLTS MCO during a member lock-in period.

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

(3) **Encounter data:** Data elements from encounters for fee-for-service or capitated service proxy claims. Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats that comprise a minimum core data set.

(4) **Enrollee:** A medicaid participant who is currently enrolled in a CLTS MCO/SE in a coordinated long-term services program.

(5) **Enrollee rights**: Rights that each coordinated long-term services enrollee is guaranteed.

(6) **Enrollment:** The process of enrolling eligible clients in a CLTS MCO/SE for purposes of management and coordination of health service delivery.

(7) **EPSDT:** Early and periodic screening, diagnostic and treatment.

(8) **Exemption:** Removal of a medicaid member from mandatory enrollment in coordinated long-term services, and placement in the medicaid fee-for-service program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the CLTS MCO/SE of a CLTS MCO/SE action.

(10) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When the child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths, and respects diversity of families.

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

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a service provider after services are rendered and billed.

(4) **Federally qualified health center (FQHC):** An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC may include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638), or an urban indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

(5) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, a CLTS MCO/SE, subcontractor, provider, or client, 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.

(6) **Full benefit dual eligible:** An individual enrolled in medicare and eligible for full medicaid benefits, not limited to covering costs, such as medicare premiums.

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

G. Definitions beginning with letter "G":

(1) **Gag order:** Subcontract provisions or CLTS MCO/SE 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 CLTS MCO/SE or its business practices.

(2) **Grievance, member:** An oral or written statement by a member expressing dissatisfaction with any aspect of a CLTS MCO/SE or its operations that is not a CLTS MCO/SE action.

(3) **Grievance, provider:** An oral or written statement by a provider to the CLTS MCO/SE expressing dissatisfaction with any aspect of a CLTS MCO/SE or its operations that is not a CLTS MCO/SE action.

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

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

(3) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, *Recipient Hearings*.)

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

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

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

I. Definitions beginning with letter "I":

(1) **IBNR (claims incurred but not reported):** Claims for services authorized or rendered for which the CLTS MCO/SE has incurred financial liability, but the claim has not been received by the CLTS MCO/SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **Individualized service plan (ISP):** An individualized service plan developed with and for members who have chronic or complex conditions, and with others involved in the member's services, to improve functional outcomes, including the standards in NMAC 8.314.2.15, *Individualized Service Plan*. An ISP includes, but is not limited to: a member's history; a summary of current medical and social needs and concerns; short and long-term service needs and goals; a list of services required and their frequency; and a description of who will provide the services. An ISP must be in accordance with the approved CMS coordinated long-term services home and community-based waiver program and New Mexico medicaid state plan.

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

J – K. [RESERVED]

L. Definitions beginning with letter "L": **Long-term services:** A continuum of services and supports, ranging from in-home and community-based services for the elderly and individuals with disabilities who need help in maintaining their independence to institutional services for those who require an institutional level of support. Throughout the continuum of long-term services and supports, the goal is to provide needed services and supports to the member while striving to maintain the member's independence to the greatest extent possible.

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed to manage, coordinate and assume financial risk on a capitated basis 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 materials include brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, yellow page advertisements, and any other presentation materials used by a CLTS MCO/SE, CLTS MCO/SE representative, or CLTS MCO/SE subcontractor to attract or retain medicaid enrollment.

(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.

(4) **Medical/clinical home:** A conceptual model that facilitates the provision of quality care that is accessible, family-centered, continuous, coordinated, compassionate and culturally competent.

(5) **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 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, mental 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 CLTS MCO/SE making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the medicaid 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; and

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(6) **Member:** A client enrolled in a CLTS MCO/SE.

(7) **Member month:** A calendar month during which a member is enrolled in a CLTS MCO/SE.

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 a CLTS MCO/SE to furnish medical or behavioral health services to the CLTS MCO's/SE's members under the provisions of the medicaid coordinated long-term services contract.

(3) **Non-contracted provider (non-network provider):** An individual service provider, clinic, group, association or facility that provides covered services but does not have a contract with the CLTS MCO/SE.

(4) **Nursing facility:** A medicare/medicaid facility licensed and certified in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to members who require these services on a continuous basis but who do not require hospital services or direct daily services from a physician.

O. [RESERVED]

P. Definitions beginning with letter "P":

(1) **Participant:** An individual who has applied for and been determined eligible for Title XIX (medicaid). A "participant" may also be referred to as a "member", "customer", "consumer", "client", or "recipient".

(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 a CLTS MCO/SE to pend approval does not extend or modify required utilization management decision timelines.

(3) **Performance improvement project (PIP):** A CLTS MCO/SE QM program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions, and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

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

(5) **Person-centered planning:** A process through which each consumer or participant is actively engaged, to the extent that the consumer or participant desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.

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

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

(8) **Post-stabilization care services:** Services related to an emergency medical condition that are provided after a member is medically stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(b) and (e) and 42 CFR §422.113(c)(iii) to improve or resolve the member's condition.

(9) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given coordinated long-term services program, but is not yet a member of a specific CLTS MCO/SE.

(10) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

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

(12) **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.

(13) **Primary care case management (PCCM):** A medical care model in which clients are assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care they receive. The primary care provider is responsible for furnishing case management services to medicaid eligible recipients that include the location, coordination,, and monitoring of primary health care services and the appropriate referral to specialty care services.

(14) **Primary care case manager:** A physician, a physician group practice, an entity that medicaid-eligible recipients employ or arrange with physicians to furnish primary care case management services or, at stat option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse midwife.

(15) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the coordinated long-term services program.

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

(17) **Provider lock-in, PCP lock-in:** A situation in which the CLTS MCO/SE requires that a member see a specific identified network provider, while ensuring reasonable access to additional services, when the CLTS MCO/SE identifies utilization of unnecessary services or when a member's behavior is detrimental or indicates a need to provide case continuity.

Q. Definitions beginning with letter "Q": **Quality assurance:** A process that is adopted by a health services entity that follows written standards and criteria. The process includes the activities of a health services entity or any of its committees that: investigate the quality of health services through the review of professional practices, home and community-based service provider practices, training and experience; investigate patient cases or conduct of licensed health service providers; or encourage proper utilization of health care services and facilities. Quality assurance follows a process of discovery, both prospective and retrospective to evaluate the program; identifies areas for remediation; and implements quality improvement strategies to ensure that appropriate and timely action is taken, as indicated.

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 CLTS MCO/SE but not paid, affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the CLTS MCO/SE.

(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 than were originally requested. The authorization is based on the client's physical health (medical needs) or behavioral health (clinical needs).

(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 a CLTS MCO/SE 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 a CLTS MCO/SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

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

S. Definitions beginning with letter "S":

(1) **Service coordination:** A specialized service management that is performed by a service coordinator, in collaboration with the member and/or the member's family or representatives as appropriate, that is person-centered, and that includes, but is not limited to: (1) identification of the member's needs, including physical health services, mental health services, social services, and long-term support services; and development of the member's ISP or treatment plan to address those needs; (2) assistance to ensure timely and coordinated access to an array of providers and services; (3) attention to addressing unique needs of members; and (4) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently from the CLTS MCO/SE and has a separately defined function with a dedicated service coordinator, but is structurally linked to the other CLTS MCO/SE systems, such as quality assurance, member services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

(2) **Service coordinator:** The individual with primary responsibility for providing service coordination/management to members who have complex service needs, including long-term service and supports or needs, or who otherwise want assistance with service planning. The service coordinator does not need to be a medical professional. The service coordinator is authorized by the CLTS MCO/SE to approve the provision and delivery of covered services.

(3) **Single statewide entity (SE):** The entity selected by the state of New Mexico through the behavioral health collaborative to perform all contract functions defined in the behavioral health request for proposals (RFP). The SE is a single contractor selected to provide all defined service responsibilities statewide, including medicaid behavioral health benefits. The SE will administer both the medicaid managed care and medicaid fee-for-service (FFS) programs for all medicaid behavioral health services. The SE shall 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 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 to as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

(4) **Special needs individual:** A medicare advantage (MA) eligible individual who is institutionalized, is entitled to medical assistance under a state plan under Title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

(5) **Special needs plan:** A specialized MA coordinated service plan for special needs individuals that exclusively or disproportionately serves special needs individuals.

(6) **State plan:** A statewide plan for medicaid services submitted for approval to CMS under Title XIX of the federal Social Security Act.

(7) **Subcontract:** A written agreement between a CLTS MCO/SE and a third party, or between a subcontractor and another subcontractor, to provide services.

(8) **Subcontractor:** A third party who contracts with a CLTS MCO/SE or a CLTS MCO/SE subcontractor for the provision of services.

(9) **Suspension or suspended provider:** A service provider that has been convicted of a program-related offense in a federal, state or local court. Items or services furnished by a suspended provider will not be reimbursed under medicaid.

T. Definitions beginning with letter "T":

(1) **Terminations of care:** The utilization management review decision made during a concurrent review that yields a denial based on the current service being no longer medically necessary.

(2) **Third party:** An individual entity or program that is or may be, liable to pay all or part of the expenditures for medicaid members for services furnished under a state plan.

(3) **Tribal facility 638:** A facility operated by a Native American or Indian tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act.

(4) **Tribal provider or indian health service (IHS) provider:** A facility that is operated by a Native American/Alaskan Indian tribe authorized to provide services as defined in the Health Care Improvement Act, 25 USC §§1601, et seq.

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, 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.

(2) **Utilization management:** A system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a member.

V. Definitions beginning with letter "V": **Value-added service:** Any service or benefit offered by the CLTS MCO/SE that is not included in the coordinated long-term services benefit package and is not a medicaid funded service, benefit or entitlement under the New Mexico Public Assistance Act.

W. Definitions beginning with letter "W": **Waiver program:** One or more of the state of New Mexico medicaid home and community-based services waiver programs.

X – Z. [RESERVED]

[8.307.1.7 NMAC – N, 8-1-08]

8.307.1.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.

[8.307.1.8 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 2 MEMBER EDUCATION

8.307.2.1 ISSUING AGENCY: Human Services Department
[8.307.2.1 NMAC – N, 8-1-08]

8.307.2.2 SCOPE: This rule applies to the general public.
[8.307.2.2 NMAC – N, 8-1-08]

8.307.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.2.3 NMAC – N, 8-1-08]

8.307.2.4 DURATION: Permanent
[8.307.2.4 NMAC – N, 8-1-08]

8.307.2.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.2.5 NMAC – N, 8-1-08]

8.307.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.2.6 NMAC – N, 8-1-08]

8.307.2.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.2.7 NMAC – N, 8-1-08]

8.307.2.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.305.2.8 NMAC – N, 8-1-08]

8.307.2.9 MEMBER EDUCATION: Medicaid members and/or their legal guardian(s) shall be educated about their rights and responsibilities; service availability and administrative rules under the coordinated long-term services program; and the meaning of member direction and how to exercise their right to make choices about their services. Member education is initiated when a member becomes eligible for medicaid and is augmented by information provided by the human services department (HSD) or its designee and the coordinated long-term services managed care organization (CLTS MCO) or the single statewide entity (SE). The CLTS MCO shall employ sufficient staff to coordinate communication with members and perform other member services functions, including problem resolution and inquiries, as designated.

A. **Policies and procedures:** The CLTS MCO shall have and comply with written policies and procedures regarding the treatment of minors; adults who are in the custody of the state; children and adolescents who are under the jurisdiction of the children, youth and families department; and any individual who is unable to exercise rational judgment or give informed consent under applicable federal and state laws and regulations. The CLTS MCO shall maintain and comply with written policies and procedures:

(1) that describe a process to detect, measure and eliminate operational bias or discrimination against enrolled members by the CLTS MCO and its subcontractors;

(2) regarding the right of members and/or their legal guardian(s) to select a primary care provider (PCP) and to make decisions regarding needed social services and supports;

(3) governing the development and distribution of marketing materials for members;

(4) that are available to members and/or their representative(s), upon request, for review during normal business hours;

(5) with respect to advance directives, the CLTS MCO shall provide adult members with written information on advance directive policies that includes a description of applicable state laws and regulations. The information must reflect changes in state laws and regulations no later than 90 days after the effective date of such

changes; and

(6) to ensure through its network providers that:

(a) written information is provided to adult members concerning their rights to accept or refuse medical or surgical treatment or home and community-based services, and to formulate advance directives; including the CLTS MCO's policies and procedures with respect to the implementation of such rights;

(b) documentation exists in the member's record concerning whether or not the member has executed an advance directive;

(c) discrimination is prohibited against a member in the provision of services or based on whether the member has executed an advance directive;

(d) compliance with federal and state laws and regulations is met;

(e) education is provided for staff and the community on issues concerning advance directives; and

(f) members are informed that complaints concerning noncompliance with advance directive requirements may be filed with the state survey and certification agency, currently the department of health.

(7) to ensure provider notification to the member regarding abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and, if clinically indicated, informing the member of a scheduled follow-up visit. Confirmation of this shall be documented in the member's record at the service provider's office; and

(8) to ensure that its network providers and facilities are in compliance with the Americans with Disabilities Act (ADA), 42 USC §§12101, et. seq., and its regulations.

B. **Initial information:** The education of the member is initiated by the eligibility determination agencies. HSD or its designee distributes information about medicaid coordinated long-term services and the enrollment process to these agencies.

C. **Enrollment information:** Once a member is determined to be a CLTS MCO/SE mandatory participant, HSD or its designee will provide the member with information about services included in the CLTS MCO/SE benefit package and the CLTS MCOs from which the member can choose to enroll as a member, including information about the member's disenrollment rights at the time of enrollment and annually thereafter.

D. **Informational materials:** The CLTS MCO/SE is responsible for providing members and potential members a member handbook and a provider directory within 30 calendar days of being notified of the member's enrollment, or upon request by the member or the state. The CLTS MCO/SE may direct a member requesting a member handbook or provider directory to an internet site, unless the member makes a specific request for a printed document. The member handbook and provider directory shall be available in formats other than English. If there is a prevalent population of 5% or more within the CLTS MCO/SE membership, as determined by the CLTS MCO/SE or HSD or its designee, these materials shall be made available in the language of the identified prevalent population. The state must grant prior approval of all informational materials used by the CLTS MCO.

(1) The CLTS MCO member handbook must include the following:

(a) CLTS MCO/SE demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hour and emergency services, including the 911 telephone system or its local equivalent;

(c) member bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information regarding language accessibility;

(e) information pertaining to coordination of services by and with primary care providers (PCPs);

(f) information regarding the member's right of access to and coverage of emergency services, including the fact that the member has a right to use any hospital or other setting for emergency services; and what constitutes an emergency medical condition, emergency services, and post-stabilization services;

(g) description of mandatory benefits;

(h) information on accessing behavioral health or other specialty services;

(i) limitations on the receipt of services from out-of-network providers;

(j) list of services for which prior authorization or a referral is required and the method of obtaining both;

(k) policy on referrals for specialty services and other benefits not furnished by the member's PCP;

(l) notice to members about the grievance process, appeals process, and HSD's fair hearing process;

(m) information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan;

(n) information regarding advance health directives;

(o) information regarding obtaining a second opinion;

(p) information on cost sharing, if any;

(q) how to obtain information, upon request, determined by HSD or its designee as essential during the member's initial contact with the CLTS MCO, which may include a request for information regarding the CLTS MCO's structure, operation, and physician's or senior staff's incentive plans;

(r) populations excluded from enrollment and subject to mandatory enrollment;

(s) physical health benefits under the medicaid state plan that are not covered by the contract, and how the member will be able to access those benefits;

(t) the CLTS MCO's policy on referrals for specialty services, long-term services and supports and other benefits; and

(u) language to clearly explain that a Native American member may self-refer to an indian health service (IHS) or tribal health care facility for services; and a separate section with a listing of all IHS and tribal facilities, including hospitals, outpatient clinics, pharmacies and dental clinics.

(2) The SE member handbook shall include the following:

(a) MCO/SE demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) member bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care with PCPs;

(e) how to obtain care in emergency and urgent conditions;

(f) description of mandatory benefits;

(g) information on accessing behavioral health services, including a discussion of the member's rights to self-refer;

(h) limitations to the receipt of care from out-of-network providers; a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) notice to members about the grievance process and about HSD's fair hearing process;

(k) information regarding advance directives;

(l) information regarding obtaining a second opinion;

(m) information on cost sharing, if any;

(n) how to obtain information, upon request, determined by HSD as essential during the member's initial contact with the SE, which may include a request for information regarding the SE's structure, operation, and physician's or senior staff's incentive plans.

(3) The provider directory must include the following:

(a) CLTS MCO/SE addresses and telephone numbers;

(b) a listing of primary care and specialty providers with the identity, location, phone number, qualifications, area of special expertise, and non-English languages spoken. CLTS MCO specialty providers for self-referral shall include, but not be limited to, family planning providers, urgent and emergency care providers, IHS, other Native American providers, and pharmacies;

(c) SE: a listing of behavioral health providers with the name, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals; and

(d) the material shall be available in a manner and format that can be easily understood by all identified prevalent populations.

D. **Other requirements:**

(1) The CLTS MCO/SE shall provide the member handbook and provider directory to enrolled members within 30 calendar days of enrollment.

(2) A listing of all benefits, services and goods, including preventive and long-term services included in and excluded from coverage shall be made available to members in a one-page, two-sided summary format, distinguishing between services available pursuant to the state's approved section 1915(b) and section 1915(c) waivers.

(3) The CLTS MCO shall send out a questionnaire to all new members that must include a question regarding the new member's primary spoken and/or written language within 30 calendar days of enrollment.

(4) The handbook and directory shall: be provided in a comprehensive, understandable format that takes into consideration special needs populations; be written in accordance with federal mandates; and meet communication requirements delineated in 8.307.8.15 NMAC, *Member Bill Of Rights*. This information may also be accessible via the Internet, and must be provided to HSD or its designee as requested.

(5) Oral and sign language interpretation must be made available free of charge to members and potential members upon request, and be available in all non-English languages.

(6) The handbook and directory must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. The CLTS MCO must have a process in place for notifying potential members and members of the availability of these alternative formats.

(7) The member handbook shall be approved by HSD or its designee prior to distribution to Medicaid members. The SE's behavioral health member (or consumer) handbook shall be approved prior to distribution by HSD or its designee.

(8) Notification of material changes in the administration of the CLTS MCO/SE, changes to the CLTS MCO's/SE's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD or its designee shall be distributed to the CLTS MCO's members 30 days prior to the intended effective date of the change. In addition, the CLTS MCO/SE shall make a good faith effort to give written notice of termination of a contracted provider to affected members within 15 days after receipt or issuance of termination notice.

(9) Notification about any of these changes may be made without reprinting the entire handbook.

(10) The CLTS MCO/SE shall notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

E. **CLTS MCO/SE policies and procedures on member education:** The CLTS MCO/SE shall maintain policies and procedures governing the development and distribution of educational material for members. Policies shall address how members and potential members receive information, the means of dissemination, and the content, comprehension level, and languages of this information. The CLTS MCO/SE shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken by its membership.

F. **Health education:** The CLTS MCO/SE shall provide a continuous program of health education without cost to members. Such a program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction. HSD or its designee shall not approve health education materials. The CLTS MCO/SE shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors.

G. **Maintenance of toll-free line:** The CLTS MCO/SE shall maintain one or more toll-free telephone lines that are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. CLTS MCO/SE members may also leave voice mail messages to obtain other CLTS MCO/SE policy information and to register grievances with the CLTS MCO/SE. The CLTS MCO/SE shall return the telephone call by the next business day.

H. **Member services meetings:** The CLTS MCO/SE shall meet as requested with HSD or its designee's staff for member services meetings. Member services meetings are held to plan outreach and medicaid enrollment activities and events that will be jointly conducted by the CLTS MCO/SE and HSD or its designee's outreach staff.

[8.307.2.9 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 3 CONTRACT MANAGEMENT

8.307.3.1 ISSUING AGENCY: Human Services Department
[8.307.3.1 NMAC – N, 8-1-08]

8.307.3.2 SCOPE: This rule applies to the general public.
[8.307.3.2 NMAC – N, 8-1-08]

8.307.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.3.3 NMAC – N, 8-1-08]

8.307.3.4 DURATION: Permanent
[8.307.3.4 NMAC – N, 8-1-08]

8.307.3.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.3.5 NMAC – N, 8-1-08]

8.307.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.3.6 NMAC – N, 8-1-08]

8.307.3.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.3.7 NMAC – N, 8-1-08]

8.307.3.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.3.8 NMAC – N, 8-1-08]

8.307.3.9 ELIGIBLE COORDINATED LONG-TERM SERVICES MANAGED CARE ORGANIZATIONS (CLTS MCOs): The human services department (HSD) shall award risk-based contracts to CLTS MCOs with statutory authority to assume risk and enter into prepaid capitation agreements that meet applicable requirements and standards delineated under state and federal law, including Title IV 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.

A. **Procurement process:** HSD shall award risk-based contracts to CLTS MCOs using a competitive procurement process that conforms to the terms of the New Mexico Procurement Code. Offerors must submit their responses to the request for proposals in conformity with the requirements specified in the request for proposals.

B. **Contract issuance:** The risk-based contracts shall be awarded for at least a two-year period. Contracts are issued to offerors meeting requirements specified under the terms of the coordinated long-term services contract.
[8.307.3.9 NMAC – N, 8-1-08]

8.307.3.10 CONTRACT MANAGEMENT: HSD or its designee is responsible for managing the medicaid contracts issued to the CLTS MCOs/SE. HSD or its designee shall provide the oversight and administrative functions to ensure CLTS MCO compliance with the terms of the medicaid contract. The collaborative or its designee shall provide the oversight and administrative functions to ensure SE compliance with the terms of its contract. HSD, as a member of the collaborative shall provide oversight of the SE contract as it relates to medicaid behavioral health services, providers and members.

A. **General contract requirements:** The CLTS MCO/SE shall meet all specified terms of the medicaid contract with HSD as it relates to medicaid members and services and the Health Insurance Portability and

Accountability Act of 1996 (HIPAA). This includes, but is not limited to, ensuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The CLTS MCO/SE shall be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. **Subcontracting requirements:** The CLTS MCO/SE may subcontract to a qualified individual or organization the provision of services defined in the benefit package or other required CLTS MCO/SE functions. The CLTS MCO may not assign, transfer or delegate key management functions such as utilization review, utilization management, or service coordination without the explicit written approval of the state. The CLTS MCO/SE 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. The CLTS MCO must oversee and be held accountable for any function or responsibility, including claims submission requirements, that it delegates to any subcontractor. The CLTS MCO shall have policies and procedures to ensure that the subcontractor meets all standards of performance mandated by the state for the coordinated long-term services program, including the use of appropriately qualified staff, application of clinical practice guidelines and utilization management, reporting capability, and ensuring access to services for members. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD and the collaborative.

(1) **Credentialing requirements:** The CLTS MCO/SE shall maintain policies and procedures for verifying that the credentials of its service providers and subcontractors meet applicable standards. The CLTS MCO/SE shall assure the prospective subcontractor's ability to perform the activities to be delegated.

(2) **Review requirements:** The CLTS MCO/SE shall maintain a fully executed original of all subcontracts and make them accessible to HSD or its designee upon request.

(3) **Minimum requirements (CLTS MCO/SE):**

(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 to operate 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 and the services to be performed under other subcontracts;

(e) subcontracts must describe how members access services provided under the subcontract;

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

(g) subcontractors shall maintain records relating to services provided to members for 10 years;

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

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

(j) subcontracts shall include a provision for the subcontractor to release any information necessary to perform any of its obligations to the CLTS MCO/SE, and that the CLTS MCO shall monitor the subcontractor's performance on an ongoing basis and subject the subcontractor to formal review according to a periodic schedule;

(k) subcontractors shall accept payment from the CLTS MCO/SE for any services included in the benefit package and cannot request payment from HSD for services performed under the subcontract;

(l) if subcontracts include primary care, long-term services, or home and community-based services, provisions for compliance with PCP requirements delineated in the CLTS MCO contract with HSD apply;

(m) subcontractors shall comply with all applicable state and federal statutes, rules and regulations, including the prohibition against discrimination;

(n) subcontracts shall have a provision for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

(o) subcontracts shall not prohibit a service provider or other subcontractor from entering into a contractual relationship with another CLTS MCO;

(p) subcontracts may not include incentives or disincentives that encourage a service provider or other subcontractor not to enter into a contractual relationship with another CLTS MCO;

(q) subcontracts shall not contain any gag order provisions nor sanctions against service providers who assist members in accessing the grievance process or otherwise protecting the interests of members;

(r) subcontracts shall specify the timeframe for submission of encounter data to the CLTS

MCO/SE;

(s) subcontractors shall be required to perform criminal background checks on all individuals providing services under the subcontract;

(t) subcontracts shall ensure that subcontractors agree to hold harmless the state and the CLTS MCO's members in the event that the CLTS MCO cannot or shall not pay for services performed by the subcontractor pursuant to the subcontract;

(u) subcontracts for pharmacy providers shall include a payment provision consistent with 1978 NMSA §59A-57-1 to 57-11, the Patient Protection Act; and

(v) 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.

(4) **Excluded providers:** The CLTS MCO/SE shall not contract with an individual provider or an entity with an individual who is an officer, director, agent, or manager who owns or has a controlling interest in the entity; has been convicted of crimes specified in Section 1128 of the Social Security Act; is excluded from participation in any other state's medicaid program, 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 a contractual relationship with an entity convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The CLTS MCO/SE 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.

[8.307.3.10 NMAC – N, 8-1-08]

8.307.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The CLTS MCO/SE shall provide the following information to HSD or its designee and updates, modifications, or amendments to HSD or its designee within 30 days:

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

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the CLTS MCO's/SE'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 CLTS MCO's/SE's relationship with parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. **Policies, procedures and job descriptions:** The CLTS MCO/SE shall establish and maintain written policies, procedures and job descriptions as required by HSD. The CLTS MCO/SE shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The CLTS MCO/SE shall provide its policies, procedures and job descriptions for key personnel, and guidelines for review to HSD or its designee upon request. The CLTS MCO/SE shall notify HSD or its designee within 30 days when changes in key personnel occur.

(1) **Review of policies and procedures:** The CLTS MCO/SE shall review its policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Modifications or amendments to current policies, procedures or job descriptions of key positions shall be made using the guidelines delineated during the procurement process. Substantive modification or amendment to key positions must be reviewed by HSD or its designee.

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

(3) **Business requirements:** The CLTS MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid coordinated long-term services and behavioral health contracts. Any change in identified key CLTS MCO/SE personnel shall conform to the requirements of the coordinated long-term services and behavioral health contracts. The CLTS MCO/SE shall retain financial records, supporting documents, statistical records, and all other records for a period of ten (10) years from the date of submission of the final expenditure report, except as specified by HSD or its designee.

(4) **Financial requirements:** The CLTS MCO/SE shall meet minimum requirements delineated by federal and state law with respect to solvency and performance guarantees for the duration of the contract. In addition, the CLTS MCO/SE shall meet additional financial requirements specified in the contract.

(5) **Member services:** The CLTS MCO/SE 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 CLTS MCO's/SE's policies and procedures shall be made available upon request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** The CLTS MCO/SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and service providers. The SE's behavioral health consumer advisory board shall also interact with the behavioral health planning council (BHPC) as directed by the collaborative. The CLTS MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. The CLTS MCO consumer advisory board shall consist of an equitable representation of the CLTS MCO's members in terms of race, gender, special populations and geographic areas of the state.

(a) The consumer advisory board members shall serve to advise the CLTS MCO and the SE respectively 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 members as they pertain to medicaid, including coordinated long-term services. The consumer advisory boards shall meet at least quarterly and keep a written record of meetings. The CLTS MCO consumer advisory board shall keep a written record of all attempts to invite and include its members in its meetings. The board roster and minutes shall be made available to HSD or its designee upon request. The CLTS MCO/SE shall advise HSD or its designee ten days in advance of meetings to be held. HSD or its designee shall attend and observe consumer advisory board meetings at its discretion.

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

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

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose monetary penalties or sanctions to the extent authorized by federal or state law:

(i) HSD retains the right to apply progressively stricter sanctions against the CLTS MCO/SE, including an assessment of monetary penalties against the CLTS MCO/SE, for failure to perform in any contract area;

(ii) unless otherwise required by law, the level of sanctions shall be based on the frequency or pattern of conduct, the severity or degree of harm posed to or incurred by members, or the integrity of the medicaid program;

(iii) penalty assessments shall range up to 5% of the CLTS MCO's/SE's medicaid capitation payment for the month in which the penalty is assessed;

(iv) any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the CLTS MCO/SE to interrupt services provided to members; and

(v) all administrative, contractual or legal remedies available to HSD shall be employed in the event that the CLTS MCO/SE violates or breaches the terms of the contract.

(d) impose other 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 service 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 member HSD or its designee determines was not enrolled, or reenrolled, or whose enrollment was terminated because of a discriminatory practice. This is subject to an overall limit of $100,000.00 under (ii) above;

(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 medicaid program. The state must deduct from the penalty the amount of overcharge and return it to the affected members.

(e) adjust automatic assignment formula;

(f) rescind marketing consent;

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

(h) appoint a state monitor, the cost of which shall be borne by the CLTS MCO/SE;
(i) deny payment;
(j) assess actual damages;
(k) assess liquidated damages;
(l) remove members with third party coverage from enrollment with the CLTS MCO/SE;
(m) allow members to terminate enrollment;
(n) suspend agreement;
(o) terminate the CLTS MCO/SE contract;
(p) apply other sanctions and remedies specified by HSD or its designee; and
(q) impose temporary management only if it finds, through on-site survey, member complaints, or any other means that:

(i) there is continued egregious behavior by the CLTS MCO/SE, including but not limited to behavior that is described in Subparagraph (d) above, or that is contrary to any requirements of 42 USC §§1396b(m) or 1396u-2; or

(ii) there is substantial risk to the health and safety of the CLTS MCO's/SE's members; or

(iii) the sanction is necessary to ensure the health and safety of the CLTS MCO's/SE's members while improvement is made to remedy violations made under Subparagraph (d) above, or until there is orderly termination or reorganization of the CLTS MCO/SE.

(iv) HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction. HSD shall not terminate temporary management until it determines that the CLTS MCO/SE can ensure that the sanctioned behavior will not reoccur. Refer to state and federal regulations for due process procedures.

[8.307.3.11 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 4 COORDINATED LONG-TERM SERVICES ELIGIBILITY

8.307.4.1 ISSUING AGENCY: Human Services Department
[8.307.4.1 NMAC – N, 8-1-08]

8.307.4.2 SCOPE: This rule applies to the general public.
[8.307.4.2 NMAC – N, 8-1-08]

8.307.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.4.3 NMAC – N, 8-1-08]

8.307.4.4 DURATION: Permanent
[8.307.4.4 NMAC – N, 8-1-08]

8.307.4.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.4.5 NMAC – N, 8-1-08]

8.307.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.4.6 NMAC – N, 8-1-08]

8.307.4.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.4.7 NMAC – N, 8-1-08]

8.307.4.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.4.8 NMAC – N, 8-1-08]

8.307.4.9 COORDINATED LONG-TERM SERVICES ELIGIBILITY: The human services department (HSD) or its designee determines eligibility for enrollment in the coordinated long-term services program.

A. **Included populations:** Populations included in the coordinated long-term services program are:
(1) individuals eligible for both medicare and medicaid (dual eligibles);
(2) medicaid-eligible individuals meeting medicaid nursing facility level of care;
(3) participants in New Mexico's disabled and elderly (D&E) waiver program (COE 91, 93, and 94);
(4) individuals 21 years of age or older who receive medicaid state plan personal care option (PCO) services;
(5) certain medicaid-eligible persons with brain injury (COE 92); and
(6) children under age 21 with physical disabilities who are eligible for long-term care services based on assessed need for nursing facility level of care and do not meet eligibility criteria set forth in New Mexico's 1915(c) developmental disabilities waiver and/or 1915(c) medically fragile waiver programs.

B. **Excluded populations:** Populations excluded from the coordinated long-term services program are:
(1) consumers residing in intermediate care facilities for the mentally retarded;
(2) consumers receiving services under 1915(c) home and community-based waiver programs for the developmentally disabled and medically fragile. Individuals receiving services under the D&E waiver program are included in the coordinated long-term services program, as specified in subparagraph (A) above;
(3) consumers participating in SALUD!;
(4) consumers eligible for medicaid category 029 or 035, family planning or pregnancy-related services;
(5) women eligible for medicaid category 052, breast and cervical cancer program; and

(6) adults ages 19-64 eligible for category 062, state coverage insurance.

[8.307.4.9 NMAC – N, 8-1-08]

8.307.4.10 SPECIAL SITUATIONS:

A. **Hospitalized members:** If a CLTS member is hospitalized at the time of disenrollment from the coordinated long-term services program or an approved switch to another CLTS MCO, the CLTS MCO shall be responsible until the date of discharge for payment for all covered facility and professional services provided within a licensed acute care facility or non-psychiatric specialty unit as designated by the New Mexico department of health. The payer at the date of hospital admission (coordinated long-term services or medicaid fee-for-service) remains responsible for services until the date of discharge. Services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments. Transition services (e.g., durable medical equipment supplies for the home) shall be the financial responsibility of the CLTS MCO. The originating and receiving organization are both required to ensure continuity and coordination of services during the transition.

B. **Members receiving hospice services:** Members who have elected and are receiving hospice services prior to enrollment in the coordinated long-term services program are exempt from enrolling in a CLTS MCO unless they revoke their hospice election.

C. **Members in third trimester of pregnancy:** A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider may continue that relationship. Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC for special payment requirements.

D. **Members placed in institutional care facilities for the mentally retarded (ICF/MR):** If a member is placed in an ICF/MR for what is expected to be a long-term or permanent placement, the CLTS MCO/SE remains responsible for the member until the member is disenrolled by HSD.

[8.307.4.10 NMAC – N, 8-1-08]

8.307.4.11 COORDINATED LONG-TERM SERVICES STATUS CHANGE: A change of medicaid eligibility for a member enrolled in a CLTS MCO/SE may result in disenrollment from the coordinated long-term services program or change of enrollment status within the CLTS MCO/SE.

A. **Effect of exclusion and exempt status on coordinated long-term services program status:** If the member's medicaid eligibility status changes so that the member is no longer a mandatory CLTS MCO/SE participant, the member shall be disenrolled from the CLTS MCO/SE. **Enrollment process immediately initiated:** If a member’s eligibility status changes requiring mandatory enrollment in the coordinated long-term services program, the enrollment process shall be initiated.

B. **Change in eligibility without change in coordinated long-term services status:** If a member's eligibility category changes and enrollment in a CLTS MCO is mandatory for the new eligibility category, the member's status as a participant in the coordinated long-term services program shall not change. Members remain enrolled in the current CLTS MCO unless another change occurs that invalidates enrollment with the current CLTS MCO.

[8.307.4.11 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 5 ENROLLMENT IN COORDINATED LONG-TERM SERVICES

8.307.5.1 ISSUING AGENCY: Human Services Department
[8.307.5.1 NMAC – N, 8-1-08]

8.307.5.2 SCOPE: This rule applies to the general public.
[8.307.5.2 NMAC, N, 8-1-08]

8.307.5.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.5.3 NMAC – N, 8-1-08]

8.307.5.4 DURATION: Permanent
[8.307.5.4 NMAC – N, 8-1-08]

8.307.5.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.5.5 NMAC – N, 8-1-08]

8.307.5.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.5.6 NMAC – N, 8-1-08]

8.307.5.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.5.7 NMAC – N, 8-1-08]

8.307.5.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.5.8 NMAC – N, 8-1-08]

8.307.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The coordinated long-term services managed care organization (CLTS MCO) shall provide an open enrollment period during which it shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to any limits contained in the contract. The CLTS MCO shall not discriminate on the basis of health status or a need for health care services. The CLTS MCO shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, or sexual orientation, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, or sexual orientation. Enrollment in the SE is mandatory for all members enrolled in managed care or medicaid fee-for-service.

B. **Selection period:** The member shall have 16 calendar days to select a CLTS MCO. If a selection is not made in 16 days, the member shall be assigned to a CLTS MCO by the human services department (HSD) or its designee. Members mandated into managed care shall be automatically assigned to the SE.

C. **Enrollment methods when no selection made:**

(1) **Enrollment with previous CLTS MCO:** The member is automatically enrolled with the previous CLTS MCO unless the CLTS MCO is no longer in good standing, is no longer contracting with HSD or has had enrollment suspended.

(2) **Enrollment based on case (family) continuity:** Enrollment based on case continuity is applied in the following manner: **Processing case continuity:** The member is enrolled with the CLTS MCO to which a majority of the case (family) members is assigned, if applicable. If an equal number of case (family) members are assigned to different CLTS MCOs and a majority cannot be identified, the member is assigned to a CLTS MCO to which other case (family) members are assigned.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, members who are not enrolled using the previous methods may be enrolled in a CLTS MCO using a percentage-based assignment

process. The percentage-based assignments for each CLTS MCO may be determined based upon consideration of the CLTS MCO's performance in areas such as quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of services, grievance resolution, claims payment, and consumer input.

D. **Begin date of enrollment:** Enrollment begins the first day of the first full month following selection or assignment, except in the following circumstances:

(1) the member is receiving hospice services in accordance with Subsection E of 8.307.4.10 NMAC, *Members receiving hospice services*;

(2) the member entered a nursing facility while enrolled in the medicaid fee-for-service (FFS) program, and both the member's nursing facility level of care and medicaid eligibility precede the first full month following selection; and

(3) if the selection or assignment is made after the 25th day of the month and before the first full day of the following month, the enrollment begins on the first day of the second month after the selection or assignment.

E. **Newly eligible enrollment and expedited service requests:** For members eligible for the first time, the CLTS MCO shall perform an assessment of the member's acute service, long-term service, behavioral health, and social support needs within the first 60 calendar days of enrollment. Authorized covered services shall be initiated within seven calendar days following the assessment. If it is determined that the member has an emergent need for covered services, the state or its designee shall coordinate with the CLTS MCO to have an assessment performed within seven business days and services initiated within 14 calendar days following the assessment.

F. **Member lock-in:** Member enrollment in a CLTS MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to a CLTS MCO, the member shall have the option to choose a different CLTS MCO to provide services during the member's remaining period of enrollment.

(1) If the member does not choose a different CLTS MCO, the member will continue to receive services from the CLTS MCO that provided the member's services during the first 90 days.

(2) If, during the member's first 90 days with a CLTS MCO, the member chooses a different CLTS MCO, the member will have a 90-day open enrollment period with the new CLTS MCO.

(3) After exercising switching rights, and returning to a previously selected CLTS MCO, the member shall remain with this CLTS MCO until the 12-month lock-in period expires before being permitted to switch again.

(4) At the conclusion of the 12-month cycle, the member shall have the same choices offered at the time of initial enrollment. The member shall be notified of the expiration of the lock-in period and the deadline for choosing a new CLTS MCO 60 days prior to the expiration date of the member's lock-in period.

(5) If a member loses medicaid eligibility for a period of six months or less, the member will be reenrolled automatically with the member's former CLTS MCO, as long as a nursing facility level of care is in place and/or the member is a full benefit dual eligible. If the member misses the annual disenrollment opportunity during this six-month time period, the member may request to be assigned to another CLTS MCO.

G. **Member switch enrollment:** A member who is required to enroll in the coordinated long-term services program may request to be disenrolled from a CLTS MCO and switch to another CLTS MCO "for cause" at any time. The member or the member's representative shall make the request in writing to HSD. HSD shall review the request and furnish a written response to the member and the CLTS MCO no later than the first day of the second month following the month in which the member or the member's representative files the request. If HSD fails to make a disenrollment determination so that the member may be disenrolled during this timeframe, the disenrollment is considered approved. A member who is denied disenrollment shall have access to HSD's fair hearing process. The following criteria shall be cause for disenrollment:

(1) continuity of service issues;

(2) family continuity;

(3) an administrative or data entry error in assigning a member to a CLTS MCO;

(4) assignment of a member where travel for primary care exceeds community standards (90% of urban residents shall travel no further than 30 miles to see a primary care provider (PCP); 90% of rural residents shall travel no further than 45 miles to see a PCP; and 90% of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the CLTS MCO service area;

(6) the CLTS MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, but not all related services can be provided by the PCP and another service provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of service, lack of access to services covered under the contract, or lack of access to service providers experienced in dealing with the member's health service needs.

H. **Exemption:** HSD shall grant exemptions to mandatory enrollment on a case-by-case basis. HSD shall grant exemptions to mandatory enrollment for medicaid managed care behavioral health services for cause on a case-by-case basis. If the exemption is granted, the member shall receive their behavioral health services through the SE under the medicaid fee-for-service (FFS) program. A member or the member's representative shall request exemption in writing to HSD, describing the special circumstances that warrant an exemption. Alternatively, HSD may initiate an exemption on a case-by-case basis. Requests for exemption shall be evaluated by HSD clinical staff and forwarded to the medical assistance division medical director or designee for final determination. Members shall be notified of the disposition of exemption requests. A member requesting an exemption, who is not enrolled in the coordinated long-term services program at the time of the exemption request, shall remain exempt until a final determination is made. A member already enrolled in the coordinated long-term services program at the time of the exemption request shall remain in the program until a final determination is made. HSD shall review the request and furnish a written response to the member no later than the first day of the second month following the month in which the member files the request. If HSD fails to make a determination so that the member may become exempt within this timeframe, the exemption is considered approved. A member who is denied exemption shall have access to HSD's fair hearing process.

I. **Disenrollment, CLTS MCO/SE initiated:** The CLTS MCO/SE may request that a particular member be disenrolled from the coordinated long-term services program. Member disenrollment from a CLTS MCO/SE shall be considered in rare circumstances. Disenrollment requests shall be made in writing to HSD. The request and supporting documentation shall meet HSD conditions stated below in Subsection I of 8.307.5.9 NMAC. The CLTS MCO/SE shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs, except when the member's continued enrollment with the CLTS MCO/SE seriously impairs the CLTS MCO's/SE's ability to furnish services to either this particular member or other members. The CLTS MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The CLTS MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the CLTS MCO/SE retains responsibility for the member's services until the member is enrolled with another CLTS MCO or exempted from the coordinated long-term services program. In the case of the SE, the member would be exempt from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The CLTS MCO/SE shall assist with transition of care.

J. **Conditions under which a CLTS MCO may request member disenrollment:** Conditions under which a CLTS MCO/SE may request disenrollment are:

(1) the CLTS MCO/SE demonstrates that a good faith effort has been made to accommodate the member and address the member's problems, but those efforts have been unsuccessful;

(2) the conduct of the member does not allow the CLTS MCO/SE to safely or prudently provide medical or behavioral health services subject to the terms of the contract;

(3) the CLTS MCO/SE has offered the member the opportunity in writing to use the grievance procedures; and

(4) the CLTS MCO/SE has received threats or attempts of intimidation from the member to the CLTS MCO's/SE's service providers or staff.

K. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be reenrolled with the requesting CLTS MCO for a period of time to be determined by HSD. The member and the requesting CLTS MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all contracted CLTS MCOs, HSD shall evaluate the member for medical management. In the case of the SE, the member would be exempt from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program.

L. **Date of disenrollment:** CLTS MCO/SE enrollment, upon approval, shall terminate at the end of a calendar month.

M. **Retroactive enrollment:** A member who is no longer enrolled with a CLTS MCO, whether in error or otherwise, shall be retroactively enrolled with the CLTS MCO when:

(1) the member continues to meet nursing facility level of care and/or continues to be a full benefit dual eligible;

(2) the member has been in a nursing facility level of care setting during the period of disenrollment; and

(3) medicaid eligibility has been determined retroactively.

[8.307.5.9 NMAC – N, 8-1-08]

8.307.5.10 ENROLLMENT ROSTERS: The CLTS MCO/SE shall receive a monthly roster with the aggregate number of members, member names, member addresses, member social security numbers, member rate cells and member capitation amounts.

[8.307.5.10 NMAC – N, 8-1-08]

8.307.5.11 MEMBER IDENTIFICATION CARD: The CLTS MCO shall issue each member a member identification card with its contact information and the SE contact information, within 30 days of enrollment. The card shall be substantially the same as the card issued to commercial members. The card shall not contain information that identifies the member as a medicaid recipient, other than designations commonly used by the CLTS MCOs to identify member benefits, such as group or plan numbers, to service providers.

[8.307.5.11 NMAC – N, 8-1-08]

8.307.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of members from one CLTS MCO to another is appropriate.

A. **Triggering mass transfer process:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in CLTS MCO identification number or name; and

(2) a significant change in CLTS MCO contracting status, including but not limited to, loss of licensure, substandard service, fiscal insolvency or significant loss in network providers.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer process begins with the first day of the month following the identification of the need to transfer CLTS MCO members.

C. **Member selection period:** Following a mass transfer, CLTS MCO members are given an opportunity to select a different CLTS MCO.

D. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when a status change of the CLTS MCO is transparent to the member. For instance, a change in the CLTS MCO's medicaid identification number is a system change that requires a mass transfer but is not relevant to the member and service continues with the CLTS MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the prior CLTS MCO experiencing the maintenance change.

E. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the CLTS MCO’s contract status changes and the change may be of significance to the member. Upon initiation of the mass transfer function by HSD, CLTS MCO members are transferred to the "transfer to" CLTS MCO and notice is sent to members informing them of the transfer and their opportunity to select a different CLTS MCO.

[8.307.5.12 NMAC – N, 8-1-08]

8.307.5.13 COORDINATED LONG-TERM SERVICES AND SINGLE STATEWIDE ENTITY MARKETING GUIDELINES: When marketing to medicaid members, the CLTS MCOs/SE shall follow these marketing guidelines:

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

(1) marketing and outreach materials must meet requirements for all communication with members, as delineated in the quality standards (8.307.8.15 NMAC, *Member bill of rights*) and incorporated into the coordinated long-term services contract;

(2) all marketing and outreach materials produced by the CLTS MCOs/SE under the medicaid coordinated long-term services and behavioral health contracts 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 prevalent population of 5% in the CLTS MCO/SE membership that has limited English proficiency, as identified by the CLTS MCO/SE or HSD, marketing materials must be available in the language of the prevalent 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 yellow page advertisements; and web site and presentation materials used by a CLTS MCO/SE, CLTS MCO/SE representative or CLTS MCO/SE subcontractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid member. The CLTS MCOs/SE are not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at medicaid members, and marketing material that mentions medicaid, medical assistance, Title XIX or makes reference to medicaid behavioral health services. The CLTS MCO/SE 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 medicaid populations, such as billboards or bus posters disproportionately located in low-income neighborhoods;

(2) mention the CLTS MCO's/SE medicaid product name; or

(3) contain language or information designed to attract medicaid enrollment.

C. **Advertising and marketing material:** The dissemination of medicaid-specific advertising and marketing materials, including materials disseminated by a subcontractor and information disseminated via the Internet, requires the approval of HSD or its designee. In reviewing this information, HSD shall apply a variety of criteria:

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

(2) **Misleading references to a CLTS MCO's/SE strengths:** Misleading information shall not be allowed, even if it is accurate. For example, a CLTS MCO/SE may seek to advertise that its health care and home and community-based services are free to medicaid members. HSD would not allow the language because it could be construed by members as being a particular advantage of the CLTS MCO/SE. In other words, members might believe that they would have to pay for medicaid health services if they chose another CLTS MCO/SE.

(3) **Threatening messages:** A CLTS MCO/SE shall not imply that another CLTS MCO/SE is endangering members' health status, personal dignity or the opportunity to succeed in various aspects of their lives. A CLTS MCO may differentiate itself by promoting its legitimate strengths and positive attributes, but not by creating threatening implications about the mandatory assignment process or other aspects of the program.

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) or whether the activity is performed by the CLTS MCO/SE directly, its network providers, its subcontractors, or any other party affiliated with the CLTS MCO/SE:

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

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

(3) initiating an enrollment request on behalf of a member;

(4) making inaccurate, misleading or exaggerated statements;

(5) asserting or implying that the CLTS MCO offers unique covered services where another CLTS MCO provides the same or similar services;

(6) the use of more than nominal gifts to entice medicaid members to join a specific health plan;

(7) telemarketing or face-to-face marketing with potential members;

(8) conducting any other marketing activity prohibited by HSD or its designee;

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

(10) distributing any marketing materials without first obtaining the approval of HSD or its designee;

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

(12) engaging in door-to-door, telephone or other cold call marketing activities, directly or indirectly; and

(13) additional marketing activities prohibited at the discretion of HSD or its designee.

E. **Marketing in current service sites:** Promotional materials may be made available to members

and potential CLTS MCO/SE members at service delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings at service delivery sites for the purpose of marketing to potential CLTS MCO/SE members by CLTS MCO/SE staff shall not be permitted.

F. **Provider communications with medicaid members about CLTS MCO/SE options:** HSD marketing restrictions shall apply to CLTS MCO/SE subcontractors and service providers, as well as to the CLTS MCO/SE. The CLTS MCO/SE is required to notify participating service 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 CLTS MCO/SE staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with members must be in compliance with the guidelines identified in these regulations.

H. **Mailings by the CLTS MCO/SE:** CLTS MCO/SE mailings shall be permitted in response to a member's oral or written request for information. The content of marketing or promotional mailings shall be prior approved by HSD or its designee. The CLTS MCOs/SE may, with HSD approval, provide potential members with information regarding the CLTS MCO/SE medicaid benefit package. The CLTS MCOs/SE shall not send gifts, however nominal in value, in these mailings. The CLTS MCOs/SE may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notices of outreach events and member services meetings; educational materials; and literature related to preventive medicine initiatives. HSD shall approve the content of mailings, except health education materials. The target audience of the mailings shall be prior approved by HSD or its designee.

I. **Group meetings:** The CLTS MCO/SE may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve any marketing materials to be presented. HSD, or its designee, shall approve the methodology used by the CLTS MCO/SE to solicit attendance for public meetings. HSD or its designee may attend public meetings.

J. **Light refreshments for members at meetings:** The CLTS MCO/SE 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 members:** The CLTS MCO/SE and its service providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, keychains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing services. Items that reinforce a member's healthy behavior, or that advertise the member services hotline or the member's PCP office telephone number are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided.

M. **Marketing time frames:** The CLTS MCOs/SE may initiate marketing and outreach activities at any time.

[8.307.5.13 NMAC- N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 6 PROVIDER NETWORKS

8.307.6.1 ISSUING AGENCY: Human Services Department
[8.307.6.1 NMAC – N, 8-1-08]

8.307.6.2 SCOPE: This rule applies to the general public.
[8.307.6.2 NMAC – N, 8-1-08]

8.307.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.6.3 NMAC – N, 8-1-08]

8.307.6.4 DURATION: Permanent
[8.307.6.4 NMAC – N, 8-1-08]

8.307.6.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.6.5 NMAC – N, 8-1-08]

8.307.6.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.6.6 NMAC – N, 8-1-08]

8.307.6.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.6.7 NMAC – N, 8-1-08]

8.307.6.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.6.8 NMAC – N, 8-1-08]

8.307.6.9 GENERAL NETWORK REQUIREMENTS: The coordinated long-term services managed care organization (CLTS MCO) and the behavioral health statewide entity (SE) shall establish and maintain a comprehensive network of providers willing and capable of serving its members.

A. **Service coverage:** The CLTS MCO/SE shall provide or arrange for the provision of services described in 8.307.7 NMAC, *Benefit Package*, in a timely manner. The CLTS MCO/SE is solely responsible for the provision of covered services and must ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards.

B. **Comprehensive network:** The CLTS MCO/SE shall contract with the full array of providers necessary to deliver a level of service at least equal to, or better than, community norms. The CLTS MCO shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service (FFS). The CLTS MCO shall have at least a single case agreement with all current medicaid nursing facility, disabled and elderly (D&E) waiver, and personal care option (PCO) providers as either out-of-network or contracted providers for at least the minimum 90 days during which the prior authorization for these services is being honored. The CLTS MCO/SE shall take into consideration the characteristics and health/long-term service needs of its individual medicaid populations. The CLTS MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In establishing and maintaining the network of appropriate providers, the CLTS MCO/SE shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members;

(2) the geographic location of providers and medicaid members, considering distance, travel time, the means of transportation ordinarily used by medicaid members; and

(3) whether the location provides physical access for medicaid members, including members with disabilities.

C. **Maintenance of provider network:** The CLTS MCO/SE shall notify the human services department (HSD) or its designee within five working days of unexpected changes to the composition of its provider network that negatively affect members' access or the CLTS MCO's/SE's ability to deliver services included in the benefit package in a timely manner. Anticipated material changes in a CLTS MCO/SE provider network shall be reported to HSD or its designee in writing within 30 days prior to the change, or as soon as the CLTS MCO/SE knows of the anticipated change. A notice of material change must contain:

(1) the nature of the change;

(2) how the change affects the delivery of or access to covered services; and

(3) the CLTS MCO/SE's plan for maintaining access and the quality of member services.

D. **Required policies and procedures:** The CLTS MCO/SE shall maintain policies and procedures on provider recruitment and termination of provider participation with the CLTS MCO/SE. Recruitment policies and procedures shall describe how a CLTS MCO/SE will respond to a change in its network that affects access and its ability to deliver services in a timely manner. The state shall have the right to review these policies and procedures upon request. The CLTS MCO/SE:

(1) must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

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

(3) must not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;

(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;

(5) shall be allowed to use different reimbursement amounts for different specialties or for different service providers within the same specialty;

(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;

(7) may not employ or contract with providers excluded from participation in federal health care programs because of misconduct;

(8) shall require that each service provider either billing or rendering services to members has a unique identifier in accordance with the provisions of Section 1173(b) of the Social Security Act;

(9) shall ensure that subcontracted direct care agencies initiate and maintain records of criminal history and background investigations for employees providing services;

(10) shall establish mechanisms to ensure that network providers comply with timely access requirements; monitor network providers regularly to determine compliance; and take corrective action with network providers for failure to comply;

(11) shall ensure that network providers are conducting abuse registry screenings in accordance with the Employee Abuse Registry Act and §§7.1.12 and 8.11.6.1 NMAC;

(12) shall require network providers to report any changes in their capacity to take new medicaid participants or serve current members; and

(13) shall not be required to contract with service providers who are ineligible to receive reimbursement under medicaid fee-for-service.

E. **General information submitted to HSD:** The CLTS MCO shall maintain an accurate unduplicated list of contracted, subcontracted and terminated primary care providers (PCPs), specialists, hospitals, and other service providers participating or affiliated with the CLTS MCO. The SE shall maintain an accurate unduplicated list of contracted, subcontracted, and terminated behavioral health providers for both mental health and substance abuse. The CLTS MCO/SE shall submit this list to HSD or its designee on a quarterly basis, and include a clear delineation of all additions and terminations that have occurred since the last submission.
[8.307.6.9 NMAC – N, 8-1-08]

8.307.6.10 PROVIDER QUALIFICATIONS & CREDENTIALING: The CLTS MCO/SE shall verify that each contracted or subcontracted service provider (practitioner or facility) participating in or employed by the CLTS MCO/SE meets applicable federal and state requirements for licensing, certification, accreditation, credentialing, and recredentialing for the type of care or services within the scope of practice as defined by federal medicaid statutes and state law. The CLTS MCO shall have written policies, procedures and standards for service providers that are not required to be licensed, certified and/or credentialed.

A. **Individual professional service providers:** For individual professional service providers, the CLTS MCO shall:

(1) have written policies and procedures for the credentialing process, including the CLTS MCO's initial credentialing of practitioners and service providers and its subsequent recredentialing, recertifying and/or reappointment of providers;

(2) designate a credentialing committee or other peer review body to make recommendations regarding credentialing decisions;

(3) identify those service providers who fall under the scope of credentialing authority and action. This shall include, at a minimum, all physicians, dentists and other licensed independent practitioners;

(4) comply with all HSD standards for credentialing and recredentialing; and

(5) formally recredential network service providers at least every three years.

B. **Organizational providers:** For organizational providers, the CLTS MCO shall:

(1) have written policies and procedures for the initial and ongoing assessment of all organizational providers with which the CLTS MCO intends to contract or with which it is contracted. Providers include, but are not limited to, hospitals, home health agencies, nursing facilities, personal care service providers, and free-standing surgical centers;

(2) confirm that the service provider is in good standing with state and federal regulatory bodies;

(3) confirm that the service provider has been reviewed and approved by applicable accrediting bodies; and

(4) develop and implement standards of participation that demonstrate that the service provider is in compliance with provider participation requirements under applicable federal law and regulations, if the service provider has not been approved by an accrediting body.

C. **Primary source verification:**

(1) HSD or its designee and the CLTS MCO shall mutually agree to a single primary source verification entity to be used by the CLTS MCO and its subcontractors in its service provider credentialing process. All CLTS MCOs shall use one standardized credentialing form. The state shall have the right to mandate a standards credentialing application to be used by the CLTS MCO and its subcontractors in its service provider credentialing process.

(2) The CLTS MCO shall provide HSD or its designee copies of all medicaid service provider specific forms used in its health system operations and credentialing/recredentialing process for prior approval. The forms shall be user-friendly. The CLTS MCO shall participate in a workshop to consolidate and standardize forms across all CLTS MCOs and for its credentialing/recredentialing process and applications.

[8.307.6.10 NMAC – N, 8-1-08]

8.307.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the CLTS MCO/SE is encouraged to utilize in-state and border service providers, which are defined as those service providers located within 100 miles of the New Mexico border, Mexico excluded. The CLTS MCO/SE may include out-of-state service providers in its network.

[8.307.6.11 NMAC – N, 8-1-08]

8.307.6.12 PRIMARY CARE PROVIDERS: The PCP must be a participating CLTS MCO medical provider that has the responsibility for supervising, coordinating and providing primary health services to members, initiating referrals for specialist services and maintaining the continuity of the member's services. The CLTS MCO shall distribute information to its PCPs explaining the medicaid-specific policies and procedures outlining PCP responsibilities.

A. **Primary care for dual eligibles:** These PCP regulations apply to all coordinated long-term services program recipients except members who are dually eligible for medicare and medicaid (dual eligibles), and whose primary and acute physical health services are covered by medicare. For dual eligible members, the CLTS MCO is responsible for coordinating the member's primary, acute and long-term care services with the medicare PCP.

B. **Primary care for Native Americans:** The CLTS MCO shall develop policies and procedures to ensure that services are coordinated with the Indian Health Service (IHS), tribal 638 programs and facilities, and other tribal entities as appropriate.

C. **Primary care responsibilities:** The CLTS MCO shall develop policies and procedures to 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 services;

(2) coordination and continuity of services with providers who participate within the CLTS MCO's network and with providers outside the CLTS MCO network according to CLTS 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 not in contract;

(4) ensuring the provision of services under the EPSDT program based on the periodicity schedule for members under age 21;

(5) requiring PCPs contracted with the CLTS MCO to vaccinate members in their offices and not refer members elsewhere for immunizations. The CLTS shall encourage its PCPs to participate in the vaccines for children program administered by the department of health (DOH);

(6) ensuring the member receives appropriate prevention services for the member's age group;

(7) ensuring that services are coordinated with other types of health and social program providers;

(8) 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; and

(9) governing how coordination with the PCP and hospitalists will occur when an individual with a special health care need is hospitalized.

C. **Types of PCPs:** The CLTS 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, gynecology, and pediatrics;

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

(3) specialists, on an individualized basis, for members whose services are more appropriately managed by a specialist, such as members with infectious diseases, chronic illnesses or disabilities;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include certified mid-level practitioners who, at the member's request, may serve as the point of first contact. In both instances, the CLTS MCO shall organize its teams to ensure continuity of services 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 service providers who meet the CLTS MCO credentialing requirements as a PCP.

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

E. **Selection or assignment to a PCP:** The CLTS MCOs 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 a CLTS MCO, the CLTS MCO shall ensure that each member may choose a PCP within a reasonable distance from the member's residence.

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

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

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

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

(iii) a member shall choose a PCP within five business days of enrollment with the CLTS MCO. A member may select a PCP from the information provided by the CLTS MCO. A member may choose a PCP anytime during this selection period. If the member does not choose a PCP within five business days, the CLTS MCO will assign one;

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

(v) the CLTS MCO shall provide the member with an opportunity to select a different PCP if the member is dissatisfied with the 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 on the first day of the following month. If the request is made after the 20th day of the month, it will become effective on the first day of the second month following the request. A PCP change may also be initiated on behalf of a member by the member's parent(s) or legal guardian(s) of a minor or incapacitated adult.

(3) **Subsequent change in PCP initiated by the CLTS MCO:** In instances that a PCP has been terminated, the CLTS MCO shall allow affected members to select another PCP or make an assignment within 15 calendar days of the termination effective date. The CLTS MCO shall notify the member in writing of the PCP's

name, location and office telephone number. The CLTS MCO may initiate a PCP change for a member under certain circumstances such as:

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

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

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

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

(e) a member's PCP is suspended for potential quality or fraud and abuse issues.

(4) **PCP lock-in:** HSD shall allow the CLTS MCO to require that a member see a certain provider while ensuring reasonable access to quality services when utilized services have been identified as unnecessary, when a member's behavior is detrimental, or when a need is indicated to provide case continuity. Prior to placing a member on PCP lock-in, the CLTS MCO shall inform the member of the intent to lock-in, including the reasons for imposing the PCP lock-in and notice that the restriction does not apply to emergency services furnished to the member. The CLTS MCO's grievance procedure shall be made available to a member disagreeing with the PCP lock-in. The PCP lock-in shall be reviewed and documented by the CLTS MCO and reported to the state every quarter. The member shall be removed from PCP lock-in when the CLTS MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

(5) **Pharmacy lock-in:** HSD shall allow the CLTS MCO to require that a member see a certain pharmacy provider for whom compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the CLTS MCO shall inform the member and the member's representative(s) of the intent to lock-in. The pharmacy lock-in shall be reviewed and documented by the CLTS MCO and reported to the state every quarter. The member shall be removed from pharmacy lock-in when the CLTS MCO has determined that the compliance issue or drug seeking behavior has been resolved and that the recurrence of the problems is judged to be improbable. The state shall be notified of all lock-in removals at the time they occur.

E. **CLTS MCO responsibility for PCP services:** The CLTS MCO shall be responsible for monitoring PCP actions to ensure compliance with CLTS MCO and HSD policies. The CLTS MCO shall communicate with and educate PCPs about special populations and their service needs. The CLTS MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.
[8.307.6.12 NMAC – N, 8-1-08]

8.307.6.13 LONG-TERM SERVICES PROVIDERS:

A. The CLTS MCO shall contract with medical providers, home and community based providers, and institutional providers that have the responsibility for supervising, coordinating and providing long-term services to members.

(1) The CLTS MCO is prohibited from excluding long-term services providers based on the proportion of high-risk members in their caseloads.

(2) The CLTS MCO shall have a formal process for provider education regarding the coordinated long-term services program, the conditions of participation in the program, and the provider's responsibilities to the CLTS MCO and its members. The state shall be provided with documentation, upon request, that such provider education is being conducted.

(3) The CLTS MCO shall retain responsibility for monitoring long-term services provider activities to ensure compliance with the CLTS MCO's policies, and state and federal policies and regulations. The CLTS MCO shall educate long-term services providers about special populations and their service needs. The CLTS MCO shall ensure that long-term services providers successfully identify and refer members to PCPs for referral to specialty providers as medically necessary.
[8.307.6.13 NMAC – N, 8-1-08]

8.307.6.14 SPECIALTY PROVIDERS:

A. The CLTS MCO/SE shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the anticipated needs of its members will be met within the CLTS MCO/SE network of service providers. The CLTS MCO/SE shall have a system in place to refer members to service providers who are not affiliated with the CLTS MCO/SE network if providers with the necessary qualifications or certifications to provide the required services do not participate in the CLTS MCO's/SE's network.

B. The CLTS MCO/SE shall have written policies and procedures for coordination of services and

the arrangement and documentation of all referrals. The CLTS MCO/SE policies and procedures shall designate the process used by the CLTS MCO/SE to ensure that referrals for all medically necessary services are available to members. The CLTS MCO/SE referral process shall be effective and efficient and not impede timely access to and receipt of services.

C. A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider, may maintain that relationship. (Refer to Paragraph (4) of Subsection H of 8.307.11.9 NMAC, *Reimbursement for Women in the Third Trimester of Pregnancy*.)

D. The CLTS MCO/SE or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that all reasonable efforts have been made to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful. [8.307.6.14 NMAC – N, 8-1-08]

8.307.6.15 ACCESS TO SERVICES: The CLTS MCO/SE shall demonstrate that its network is sufficient to meet the health service needs of enrolled members. HSD or its designee shall assess the sufficiency of this network throughout the contract period. The CLTS MCO/SE shall notify HSD or its designee of changes in its network as required. Changes affecting member access to services shall be communicated to HSD or its designee and remedied by the CLTS MCO/SE in an expeditious manner.

A. **Provider to member ratios:**

(1) **PCP to member ratios:** The CLTS MCO shall ensure that the member caseload of any PCP in its network does not exceed 1,500 of its own members. Exceptions to this limit may be made with the consent of the CLTS MCO and HSD or its designee. Reasons for exceeding the limit may include continuation of established services, assignment of a family unit or availability of mid-level clinicians in the practice that expand the capacity of the PCP.

(2) **Specialist to member ratios:** HSD shall not establish specific specialist to member ratios. The CLTS MCO/SE must ensure that its members have adequate access to specialty services.

B. **Compliance with specified access standards:** The CLTS MCO/SE shall comply with all access standards delineated under the terms of the medicaid coordinated long-term services contract with respect to geographic location and scheduling and wait times.

C. **Requirements for CLTS MCO/SE policies and procedures:** The CLTS MCO/SE shall maintain written policies and procedures describing how members and service providers receive instructions on accessing services, including prior authorization and referral requirements for various types of medical or surgical treatments, emergency room services, and behavioral health services. The policies and procedures shall be made available in an accessible format, upon request, to HSD or its designee, network providers and members. [8.307.6.15 NMAC – N, 8-1-08]

8.307.6.16 OTHER PROVIDERS: The CLTS MCO/SE shall demonstrate how it incorporates and utilizes certain other service providers that serve many of the special needs of medicaid members and are considered important in maintaining continuity of services.

A. **Federally qualified health centers (FQHCs) and rural health centers:** The CLTS MCOs/SE shall contract with FQHCs and rural health centers to the extent that access is required by federal law and pursuant to state regulations.

B. **Public health providers:** The CLTS MCOs/SE shall contract with public health service providers, including local and district public health offices, pursuant to state law and regulations.

(1) **Specific requirements for local and district health offices:** The CLTS MCO must contract with local and district public health offices to provide the following services:

(a) family planning services;

(b) the CLTS MCO may require PCPs to participate in the vaccines for children (VFC) program administered by the department of health; and

(c) the CLTS MCO may contract with local and district health offices for other clinical preventive services not otherwise available in the community, such as prenatal services or perinatal case management.

(2) **Shared responsibility between CLTS MCO and public health offices:** The CLTS MCO shall coordinate with public health offices regarding the following services:

(a) screening, diagnosis, treatment, follow-up and contact investigations of sexually transmitted disease;

(b) HIV prevention counseling, testing and early intervention;

(c) screening, diagnosis and treatment of tuberculosis;

(d) disease outbreak prevention and management, including reporting according to state law requirements, responding to epidemiology requests for information and coordination with epidemiology investigations and studies;

(e) referral and coordination to ensure maximum participation in the supplemental food program for women, infants and children (WIC);

(f) health education services for individuals and families with a particular focus on injury prevention including, but not limited to, car seat use, domestic violence, substance use, and lifestyle issues including tobacco use, exercise and nutrition;

(g) development and support for family support programs, such as home visiting programs for families of newborns and other at-risk families and parenting education;

(h) participating in and support for local health councils to create healthier and safer communities with a focus on coordination of efforts such as DWI councils, maternal and child health councils, tobacco coalitions, safety councils, safe kids and others; and

(i) vaccines for children program.

C. **Children's medical services:** The CLTS MCO shall contract with children's medical services, which administers outreach clinics at sites throughout the state. The children's medical service clinics offer pediatric sub-specialty services in local communities, which include cleft palate, neurology, endocrine, asthma and pulmonary services.

D. **School-based providers:** The CLTS MCO/SE must make every effort to include school-based health clinics as network providers or provide the same level of access in the school setting.

E. **Assisted living facilities:** The CLTS MCO shall ensure that assisted living network providers meet the fundamental principles of practice for home and community-based services, as set forth in the coordinated long-term services contract.

F. The CLTS MCO shall contract with other service providers, as needed, to provide services identified in the member's individualized service plan (ISP).

G. **Indian health services (IHS) and tribal health centers:** The CLTS MCO/SE shall allow members who are Native American to seek services from IHS, tribal or urban Indian program service providers defined in the Indian Health Care Improvement Act (25 U.S.C. §§1601 et seq.), whether or not the service provider participates as part of the CLTS MCO's or SE's provider network. The CLTS MCO/SE may not prevent members who are IHS beneficiaries from seeking services from IHS, tribal or urban Indian service providers. The CLTS MCO/SE shall make good faith efforts to contract with service providers that include, but are not limited to, IHS, 638 tribal programs and service providers serving particular linguistic or cultural groups. The CLTS MCO/SE shall track IHS utilization and expenditures by Native American members. The CLTS MCO/SE shall not require prior authorization for services provided within the IHS and tribal 638 network. The CLTS MCO/SE shall accept an individual service provider employed by the IHS or tribal 638 facility who holds a current license to practice in the United States or its territories as meeting licensure requirements.

H. **State-run institutions.** The CLTS MCO/SE shall make every effort to use certain state-run institutions that provide highly specialized services and provide a "safety net" function for certain high-risk populations.

[8.307.6.16 NMAC – N, 8-1-08]

8.307.6.17 FAMILY PLANNING PROVIDERS: Federal law does not allow restricting access to family planning services for individuals enrolled in medicaid.

A. The CLTS MCO shall maintain written policies and procedures defining how members are educated about their right to family planning services, freedom of provider choice and method of accessing such services. The CLTS MCO shall ensure that its policies and procedures for accessing family planning services meet specified requirements for member communication.

B. The CLTS MCO shall give each member, including adolescents, the opportunity to use the member's PCP, or go to any family planning center, for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a women's health specialist within the CLTS MCO's network for covered services necessary to provide women's routine and preventive health care services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

C. Clinics and service providers, including those funded by Title X of the Public Health Service Act, shall be reimbursed by the CLTS MCO, regardless of whether they are network or non-network providers. The

CLTS MCO shall implement procedures to reimburse out-of-network family planning providers that serve its members.

D. Non-participating service providers are responsible for keeping family planning information confidential in favor of the individual patient, even if the patient is a minor.

[8.307.6.17 NMAC – N, 8-1-08]

8.307.6.18 PROVIDER EDUCATION AND COMMUNICATION:

A. The CLTS MCO/SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding coordinated long-term services, including behavioral health, to its network providers. Policies and procedures shall:

(1) inform service providers of the conditions of participation with the CLTS MCO/SE;

(2) inform service providers of their responsibilities to the CLTS MCO/SE and to medicaid members;

(3) inform service providers of medicaid-specific policies and procedures, including information on primary and specialized medical services and related information and services specific to the needs of individuals with special health care needs (ISHCN) and other special populations;

(4) inform service providers regarding cultural competency and provide ongoing educational opportunities for providers and their staff on cultural competency;

(5) provide information on credentialing and recredentialing, prior authorization and referral processes and how to request and obtain a second opinion;

(6) inform service providers on how to access service coordination services for physical, behavioral and social support needs, including covered benefits and services outside the benefit package;

(7) inform service providers regarding the delivery of federally mandated EPSDT services; and

(8) furnish service providers with information on the CLTS MCO's/SE's internal provider grievance process by which providers can dispute a CLTS MCO/SE action and/or file a complaint.

B. In addition to the above, the CLTS MCO/SE shall:

(1) conduct an annual service provider satisfaction survey, the results of which will be incorporated into the CLTS MCO's/SE's quality improvement (QI) program. Survey results will be forwarded to HSD or its designee;

(2) actively solicit input from its network providers in an effort to improve and resolve problem areas related to the coordinated long-term services program. The information provided will be incorporated into the CLTS MCO's or SE's QI program; and

(3) submit an annual service provider educational training schedule to HSD or its designee that includes the scheduled trainings for its network providers. The CLTS MCO/SE shall provide HSD or its designee with evidence, when requested, of ongoing provider educational activities scheduled throughout the year and throughout the state. Evidence of such activities may include: a provider education schedule of events held throughout the state; provider manuals distributed to contracted providers and updated at least quarterly; publications, such as brochures and newsletters; media, such as films, videotaped presentations and seminars; and schedules of classroom instruction.

C. The CLTS MCO/SE shall maintain and continue these activities with its network providers throughout the term of the CLTS MCO/SE provider contractual relationship.

[8.307.6.18 NMAC – N, 8-1-08]

8.307.6.19 CLTS MCO/SE PROVIDER TRANSITION OF CARE: The CLTS MCO shall notify HSD or its designee and the SE shall notify the collaborative of unexpected changes in the composition of its service provider network that would have a significantly negative effect on member access to services or on the CLTS MCO's/SE'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 its contractual obligation, the CLTS MCO shall be required to submit a transition plan(s) to HSD or its designee for all affected members and the SE shall be required to submit transition plans to the collaborative for all affected consumers.

[8.307.6.19 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 7 BENEFIT PACKAGE

8.307.7.1 ISSUING AGENCY: Human Services Department
[8.307.7.1 NMAC – N, 8-1-08]

8.307.7.2 SCOPE: This rule applies to the general public.
[8.307.7.2 NMAC – N, 8-1-08]

8.307.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.7.3 NMAC – N, 8-1-08]

8.307.7.4 DURATION: Permanent
[8.307.7.4 NMAC – N, 8-1-08]

8.307.7.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.7.5 NMAC – N, 8-1-08]

8.307.7.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.7.6 NMAC – N, 8-1-08]

8.307.7.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.7.7 NMAC – N, 8-1-08]

8.307.7.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.7.8 NMAC – N, 8-1-08]

8.307.7.9 BENEFIT PACKAGE: This part defines the medicaid benefit package for which the coordinated long-term services managed care organization (CLTS MCO) shall be paid fixed per-member per-month payment rates. The CLTS MCO shall cover these services. The CLTS MCO shall not delete benefits from the medicaid-defined benefit package. The CLTS MCO must utilize service providers licensed in accordance with state and federal requirements to deliver services.
[8.307.7.9 NMAC – N, 8-1-08]

8.307.7.10 MEDICAL ASSISTANCE DIVISION PROGRAM POLICY MANUAL: The medical assistance division program policy manual contains a detailed explanation of the services covered by medicaid, limitations to and exclusions of covered services, and services that are not covered by medicaid. The manual is the official source of information on covered and noncovered services. The CLTS MCO shall determine its own utilization management (UM) protocols that are based on reasonable medical evidence and are not bound by those found in the medicaid program manual. The human services department (HSD) or its designee must review and approve the CLTS MCO's UM protocols.
[8.307.7.10 NMAC – N, 8-1-08]

8.307.7.11 SERVICES INCLUDED IN THE COORDINATED LONG-TERM SERVICES PROGRAM BENEFIT PACKAGE: The CLTS MCO must provide a comprehensive, coordinated, and fully integrated system of health care, long-term services, and social and community services to its members. The following are State Plan services provided under the authority of the 1915(b) waiver and are available to all CLTS members.

A. **Ambulatory surgical services (CLTS MCO):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as set forth in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

B. **Anesthesia services (CLTS MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as set forth in 8.310.5 NMAC, *Anesthesia Services*.

C. **Audiology services (CLTS MCO):** The benefit package includes audiology services, as set forth in 8.324.6 NMAC, *Hearing Aids and Related Evaluation*.

D. **Case management services (CLTS MCO):** The benefit package includes the following case management services:

(1) **Case management services for pregnant women and their infants (CLTS MCO):** Case management services provided to pregnant women up to 60 days following the end of the month of the delivery, as set forth in 8.326.3 NMAC, *Case Management Services for Pregnant Women and their Infants*;

(2) **Case management services for traumatically brain injured adults (CLTS MCO):** Case management services provided to adult members (21 years of age or older) who are traumatically brain injured, as set forth in 8.326.6 NMAC, *Case Management Services for Traumatically Brain Injured Adults*;

(3) **Case management services for children up to the age of three (CLTS MCO):** Case management services provided to children up to the age of three who are medically at risk due to family conditions and not developmentally delayed, as detailed in 8.326.6 NMAC, *Case Management Services for Children up to Age Three*; and

(4) **Case management services for the medically at risk (CLTS MCO):** Case management services for individuals who are under 21 and are medically at risk for physical or behavioral health conditions, as set forth in 8.320.5 NMAC, *EPSDT Case Management*. "Medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition that has a high probability of impairing their cognitive, emotional, neurological, social, behavioral, or physical development.

E. **Dental services (CLTS MCO):** The benefit package includes dental services, as set forth in 8.310.7 NMAC, *Dental Services*.

F. **Diagnostic imaging and therapeutic radiology services (CLTS MCO/SE):** The benefit package includes medically necessary diagnostic imaging and radiology services, as set forth in 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services*. Radiology costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders radiology services but completes those tests in his/her office/facility and bills for it, the SE shall be responsible for payment. Radiology costs shall be the responsibility of the CLTS MCO when a BH provider orders radiology services that are performed by an outside, independent radiology facility, including those radiology services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other diagnostic imaging and therapeutic radiology services shall be the responsibility of the CLTS MCO.

G. **Dialysis services (CLTS MCO):** The benefit package includes medically necessary dialysis services, as set forth in 9.325.2 NMAC, *Dialysis Services*. Dialysis providers shall assist members in applying for and pursuing final medicare eligibility determination.

H. **Durable medical equipment and medical supplies (CLTS MCO):** The benefit package includes the purchase, delivery, maintenance, and repair of equipment, oxygen, and oxygen administration equipment, nutritional products, disposable diapers, and disposable supplies essential for the use of the equipment, as set forth in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies.*

I. **Emergency services (CLTS MCO/SE):** The benefit package includes emergency and post-stabilization care services. Emergency services are inpatient and outpatient services that are furnished by a qualified service provider and that are needed to evaluate or stabilize an emergency condition. An emergency condition shall meet the definition of emergency, as set forth in 8.307.1.7 NMAC, *Definitions*. The CLTS MCO shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. Emergency services shall be provided in accordance with 8.307.7.11(F) NMAC. Post-stabilization care services are covered services related to an emergency condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition, such that within reasonable medical probability, no material deterioration of the member's condition is likely to result from or occur during discharge of the member or transfer of the member to another facility.

J. **EPSDT services (CLTS MCO/SE):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnosis and treatment (EPSDT) services set forth in 8.320.2 NMAC, *EPSDT Services*, and the following:

(1) **EPSDT private duty nursing (CLTS MCO):** Private duty nursing for the EPSDT population, as set forth in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall be delivered in the member's home or the school setting;

(2) **EPSDT personal care (CLTS MCO):** Medically necessary personal care services furnished to members under 21 years of age as part of EPSDT, as set forth in 8.323.2 NMAC, *EPSDT Personal Care Services*;

(3) **Tot-to-teen health checks (CLTS MCO):** The CLTS MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks), including:

(a) education of and outreach to members regarding the importance of health checks;

(b) development of a proactive approach to ensure that the services are received by members;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with the CLTS MCO's network providers regarding screens and treatment coordination for members;

(e) process to document, measure and ensure compliance with the periodicity schedule; and

(f) development of a proactive process to ensure the appropriate follow-up of evaluations, referrals and/or treatment, especially early intervention for mental health conditions, vision and hearing screens, and current immunizations.

K. **Health education and preventive services:** The CLTS MCO shall:

(1) provide a continuous program of health education without cost to its members. Such a program includes publications, media, presentations, and classroom instruction;

(2) provide programs of wellness education;

(3) make preventive service available to members. The CLTS MCO shall periodically remind and encourage members to use benefits, including physical examinations, that are available and designed to prevent illness;

(4) initiate targeted prevention initiatives for members with acute and chronic disease; and

(5) develop policies and procedures that encourage the proactive performance of home safety evaluations for all at-risk members transitioning from institutions to community settings.

L. **Home health services (CLTS MCO):** The benefit package includes home health services, as set forth in 8.325.9 NMAC, *Home Health Services.*

M. **Hospice services (CLTS MCO):** The benefit package includes hospice services, as set forth in 8.325.4 NMAC, *Hospice Care Services.*

N. **Hospital outpatient services (CLTS MCO/SE):** The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative, or palliative medical or behavioral health services, as set forth in 8.311.2 NMAC, *Outpatient Covered Services*.

O. **Inpatient hospital services (CLTS MCO/SE):** The benefit package includes hospital inpatient acute care, procedures and services, as set forth in 8.311.2, *Hospital Services*. The CLTS MCO/SE shall comply with the maternity length of stay as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Coverage for a hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may not be limited to less than 96 hours for both the mother and newborn child.

P. **Laboratory services (CLTS MCO/SE):** The benefit package includes all laboratory services provided according to the applicable provisions of the Clinical Laboratory Improvement Act (CLIA), as set forth in 8.324.2 NMAC, *Laboratory Services*. Laboratory costs shall be the responsibility of the SE when they are provided within, and billed by, a freestanding psychiatric hospital, a PPS exempt unit of a general acute hospital or UNM psychiatric emergency room. In the event that a psychiatrist orders lab work but completes that lab work in his/her office/facility and bills for it, the SE shall be responsible for payment. Lab costs shall be the responsibility of the CLTS MCO when a BH provider orders lab work that is performed by an outside, independent laboratory, including those lab services provided for persons within a freestanding psychiatric hospital, a psychiatric unit, a psychiatric unit within a general hospital or UNM psychiatric ER. All other covered laboratory services shall be the responsibility of theCLTS MCO.

Q. **Nursing facility services (CLTS MCO):** The benefit package includes services provided in nursing facilities or hospital swing beds to members expected to reside in those facilities, as set forth in MAD-731, *Nursing Facilities*, and MAD-723, *Swing Bed Hospital Services*.

R. **Nutritional services (CLTS MCO):** The benefit package includes nutritional services furnished to pregnant women and children, as set forth in 8.324.9 NMAC, *Nutritional Services.*

S. **Personal care option (PCO) services (CLTS MCO):** The benefit package includes PCO services, as set forth in 8.315.4 NMAC, *Personal Care Option Services*.

T. **Pharmacy services (CLTS MCO/SE):** The benefit package includes all pharmacy and related services, as set forth in 8.324.4 NMAC, *Pharmacy Services*. The CLTS MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The CLTS MCO/SE shall use a single medicaid preferred drug list (PDL). The CLTS MCO/SE shall cover brand name drugs and drug items not generally on the CLTS MCO/SE formulary or PDL when determined to be medically necessary by the CLTS MCO/SE or through a fair hearing process. The CLTS MCO/SE shall include on their formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one (1) therapeutic ingredient, anti-obesity items, items which are not medically necessary, and cough, cold and allergy medications. The CLTS MCO/SE shall reimburse family planning clinics, school-based health clinics, and DOH public health clinics for oral contraceptive agents and Plan B when dispensed to members and billed using HCPC codes and CMS 1500 claim forms. The CLTS MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the CLTS MCO and the member's PCP when administering pharmacy services. The SE shall be responsible for payment of all drug items prescribed by a behavioral health provider, such as psychiatrists, psychologists certified to prescribe, psychiatric clinical nurse specialists, psychiatric nurse practitioners, and any other prescribing practitioner contracted with the SE.

(1) The CLTS MCO's preferred drug list (PDL) shall use the following guidelines:

(a) there must be at least one representing drug for each of the categories in the first data bank blue book;

(b) generic substitution shall be based on "AB" rating and/or clinical need;

(c) for a multiple source, brand name product within a therapeutic class, the CLTS MCO may select a representative drug;

(d) the PDL shall follow the centers for medicare and medicaid services (CMS) special guidelines relating to drugs used to treat HIV infection;

(e) the PDL shall include coverage of certain over the counter (OTC) drugs by a licensed practitioner; and

(f) the CLTS MCO shall implement an appeals process for service providers who believe that an exception to the PDL should be made for an individual member.

(2) The CLTS MCO shall use a PDL developed with consideration of the clinical efficiency, safety and cost effectiveness of drug items, and shall provide medically appropriate drug therapies for members. Drug items not on the PDL must be considered for coverage on a prior authorization basis. Atypical antipsychotic medications must be available in the same manner as conventional antipsychotic medications for the treatment of severe mental illness, including schizophrenia, clinical depression, bipolar disorder, anxiety-panic disorder, and obsessive-compulsive disorder. Upon development, the CLTS MCO will be required to deliver its pharmacy benefit package using a single medicaid PDL.

(3) The CLTS MCO shall coordinate as necessary with the single statewide entity (SE) when administering pharmacy services, to ensure that member and service provider questions are directed appropriately. The CLTS MCO shall edit pharmacy claims to ensure that any authorizations given and claims paid are within the scope of the responsibility of the CLTS MCO or the CLTS MCO's pharmacy subcontractor, and shall inform members or providers when the claims fall under the scope of responsibility of the SE. Such determinations will be based primarily on the prescriber and other criteria as provided by the state.

(4) The CLTS MCO shall maintain written policies and procedures governing its drug utilization review (DUR) program, in compliance with federal and state law and regulations;

(5) The CLTS MCO shall coordinate the delivery of the pharmacy benefit when medicare part D is the primary coverage; and

(6) The CLTS MCO shall ensure that any member who takes nine or more different prescription medications has their medications reviewed by a medical clinician for appropriateness and the identification and correction of potentially harmful practices, and shall document this review in the member's chart at least every six months

U. **Physical health services (CLTS MCO):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner and performed within their scope of practice, as defined by state law and set forth in 8.310.2.9 NMAC, *Medical Services Providers*; 8.310.9 NMAC, *Midwife Services*, including attending out-of-hospital births and other related birthing services performed by certified nurse midwives or direct-entry midwives licensed by the state of New Mexico, who are either: (1) validly contracted with and fully credentialed by the CLTS MCO, or (2) validly contracted with the HSD medical assistance division and participate in HSD's birthing options program; 8.310.11 NMAC, *Podiatry*

Services; 8.310.3 NMAC, *Rural Health Clinic Services*; and 8.310.4 NMAC, *Federally Qualified Health Center Services*.

V. **Pregnancy termination services (CLTS MCO):** The benefit package includes coverage of pregnancy terminations for rape, incest and endangerment to the life of the mother, as allowed in accordance with 42 CFR §441.202. A certification from the network provider must be provided prior to payment. Medically necessary pregnancy terminations that do not meet the requirements of 42 CFR §441.202 are excluded from the capitation payment made to the CLTS MCO, and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC, *Pregnancy Termination Procedures*.

W. **Preventive health services (CLTS MCO):** The benefit package includes preventive health services, including:

(1) **Immunizations:** The CLTS MCO shall ensure that, within six months of enrollment, members are current with immunizations according to the type and schedule provided by the most recent version of the recommendations of the advisory committee on immunization practices (ACIP) of the centers for disease control and prevention, public health service, U.S. department of health and human services. This may be done by providing the necessary immunizations or by verifying the immunization history by a method deemed acceptable by the ACIP. "Current" is defined as no more than four months overdue.

(2) **Screens:** The CLTS MCO shall ensure that, to the extent possible, asymptomatic members receive and are current for at lest the following screening services within six months of enrollment or within six months of a change in the standard. The CLTS MCO shall require its network providers to perform the appropriate interventions based on the results of the screens. "Current" is defined as no more than four months overdue. The CLTS MCO shall ensure that clinically appropriate follow-up and/or intervention is performed when indicated by the screening results.

(a) **Screening for breast cancer:** Female members age 50-69 who are not at high risk for breast cancer shall be screened annually with mammography and a clinical breast examination. Female members at high risk for developing breast cancer shall be screened as often as clinically indicated.

(b) **Screening for cervical cancer:** Female members with a cervix shall receive papanicolaou (PAP) testing starting at the onset of sexual activity, but at least by 18 years of age, and every three years thereafter until reaching 65 years of age, if prior testing has been consistently normal and the member has been confirmed to be not at high risk. If the member is at high risk, the testing frequency shall be at least annual.

(c) **Screening for colorectal cancer:** Members age 50 and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy at a periodicity determined by the CLTS MCO.

(d) **Blood pressure measurement:** Members of all ages shall receive a blood pressure measurement as medically indicated.

(e) **Serum cholesterol measurement:** Male members age 35-65 and female members age 45-65 who are at normal risk for coronary heart disease shall receive serum cholesterol measurement every five years. Those members with multiple risk factors shall also receive HDL-C measurement.

(f) **Screening for obesity:** All members shall receive annual body weight and height measurements to be used in conjunction with a calculation of the body mass index or referenced to a table of recommended weights.

(g) **Screening for elevated lead levels:** Members age nine to 15 months (ideally 12 months old) shall receive a blood lead measurement at least once.

(h) **Screening for diabetes:** Members shall receive a fasting or two-hour post-prandial serum glucose measurement at least once.

(i) **Screening for tuberculosis:** Members shall receive a tuberculin skin test based on the level of individual risk for development of the infection.

(j) **Screening for rubella:** Female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology at their first clinical encounter in an office setting.

(k) **Screening for visual impairment:** Members three to four years of age shall be screened at least once for amblyopia and strabismus by physical examination and a stereo acuity test.

(l) **Screening for hearing impairment:** Members age 50 and older shall be routinely screened for hearing impairment by questioning them about their hearing.

(m) **Screening for problem drinking and substance abuse:** Adolescent and adult members shall be screened at least once by a careful history of alcohol use and/or the use of a standardized screening questionnaire, such as the alcohol use disorders identification test (AUDIT) or the four-question CAGE instrument

and the substance abuse screening and severity inventory (SASSI). The frequency of screening shall be determined by the results of the first screen and other clinical indications. Members shall be referred to the SE as warranted.

(n) **Prenatal screening:** Pregnant members shall be screened for preeclampsia, D (Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, and vaginal and rectal group B streptococcal infection; and counseled and offered testing for HIV.

(o) **Newborn screening:** At a minimum, newborn members shall be screened for phenylketonuria, congenital hypothyroidism, galactosemia, and any other congenital disease or condition specified in accordance with department of health regulations, specifically 7 NMAC 30.6, *Newborn Genetic Screening Program*.

(p) **Behavioral health screening:** During an encounter with a primary care provider (PCP), a behavioral health screen shall occur.

(3) **Tot-to-teen health checks:** The CLTS MCO shall operate a tot-to-teen health check program for members up to 21 years of age to ensure the delivery of federally mandated EPSDT services. Within six months of enrollment, the CLTS MCO shall endeavor to ensure that eligible members are current according to the screening schedule for EPSDT services.

(4) **Counseling services:** The CLTS MCO shall provide to applicable asymptomatic members counseling on the following unless member refusal is documented: to prevent tobacco use; to promote physical activity; to promote a healthy diet; to prevent osteoporosis and heart disease in menopausal female members; to prevent motor vehicle injuries; to prevent household and recreational injuries; to prevent dental and periodontal disease; to prevent HIV infection and other sexually transmitted diseases; and to prevent unintended pregnancies.

(5) **Health advisor hotline:** The CLTS MCO shall provide a toll-free health advisor hotline, which shall provide at least the following:

(a) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic conditions;

(b) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(c) pre-diagnostic and post-treatment service decision assistance based on symptoms.

(6) **Family planning policy (CLTS MCO):** The CLTS MCO shall have a written family planning policy to ensure that members of the appropriate age of both sexes who seek family planning services shall be provided with counseling pertaining to the following: methods of contraception; evaluation and treatment of infertility; risk reduction practices for HIV and other sexually transmitted diseases; options for pregnant members who do not wish to keep a child; and options for pregnant members who may wish to terminate the pregnancy.

(7) **Prenatal care program (CLTS MCO):** The CLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal services consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(a) educational outreach to all members of childbearing ages;

(b) prompt and easy access to obstetrical services, including providing an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(c) risk assessment of all pregnant members to identify high risk cases for special management;

(d) counseling that strongly advises voluntary testing for HIV;

(e) case management services to address the special needs of members who have a high risk pregnancy, especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(f) screening for determination of need of a post-partum home visit; and

(g) coordination with other services in support of good prenatal care, including transportation and other community services and referral to an agency that dispenses free or reduced price baby car seats.

X. **Prosthetics and orthotics (CLTS MCO):** The benefit package includes prosthetic and orthotic services, as set forth in 8.324.8 NMAC, *Prosthetics and Orthotics*.

Y. **Rehabilitation services (CLTS MCO):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as set forth in 8.325.8 NMAC, *Rehabilitation Services*; and licensed speech and language pathology services furnished under the EPSDT program, as set forth in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*.

Z. **Reproductive health services (CLTS MCO):** The benefit package includes reproductive health services, as set forth in 8.325.3 NMAC, *Reproductive Health Services*. The CLTS MCO shall provide members with sufficient information to allow them to make informed choices, including: the types of family planning services available; the member's right to access these services in a timely and confidential manner; and the freedom to

choose a qualified family planning provider. A female member shall have the right to self-refer to a women's health specialist within the CLTS MCO's provider network for covered services necessary to provide women's routine and preventive health care services. This right o self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist.

AA. **School-based services (CLTS MCO/SE):** The benefit package includes services provided in schools, excluding those specified in the individualized education plan (IEP) or individualized family service plan (IFSP), as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age.*

BB. **Service coordination:** The benefit package includes service coordination that is person-centered and intended to support members in pursuing their desired life outcomes by assisting them in accessing support and services necessary to achieve the quality of life that they desire in a safe and healthy environment. Service coordination assists members in gaining access to needed coordinated long-term services program waiver services; medicaid state plan services; and medical, social, educational and other services, regardless of the funding source for the services to which access is needed.

CC. **Telehealth Services (CLTS MCO/SE):** The benefit package includes telehealth services as set forth in 8.310.13 NMMAC, *Telehealth Services.*

DD. **Transplant services (CLTS MCO):** The following transplants are covered in the benefit package as long as the indications are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants, and corneal transplants, as set forth in 8.325.5 NMAC, *Transplant Services*. Also see 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies* for guidance on determining if transplants are experimental or investigational.

EE. **Transportation services (CLTS MCO):** The benefit package includes transportation services such as ground ambulance, air ambulance, taxicab and/or handivan, commercial bus, commercial air, meal, and lodging services, as indicated for medically necessary physical and behavioral health services, as set forth in 8.324.7 NMAC *Transportation Services*. In addition, the CLTS MCO must abide by New Mexico law and regulations, specifically NMSA 1978 §65-2-97(F), stating that rates paid by the CLTS MCO to transportation providers are not subject to and are exempt from New Mexico public regulation commission approved tariffs. The CTLS MCO is also required to coordinate, manage and be financially responsible for the delivery of the transportation benefit to members receiving physical health services and/or behavioral health services. The CTS MCO shall coordinate with the SE as necessary to perform this function. Such coordination shall include:

(1) receiving information from and providing information to the SE regarding members and service providers;

(2) meeting with the SE to resolve provider and member issues to improve services, communication and coordination;

(3) contacting the SE, as necessary, to provide quality transportation services; and

(4) maintaining and distributing statistical information and data as may be required.

FF. **Vision services (CLTS MCO):** The benefit package includes vision services, as set forth in 8.310.6 NMAC, *Vision Care Services*.

The following are services provided under the 1915 (c) waiver to CLTS members who meet specific criteria.

A. **Adult day health services (CLTS MCO):** The benefit package includes adult day health services, which are generally provided for two or more hours per day on a regularly scheduled basis, for one or more days per week, by a licensed adult day-care, community-based facility that offers health and social services to assist eligible members in achieving optimal functioning. Private duty nursing services and skilled maintenance therapies (physical, occupational and speech therapies) may be provided in conjunction with adult day health services by the adult day health service provider or by another service provider. Private duty nursing services and skilled maintenance therapies must be provided in a private setting at the facility.

B. **Assisted living services (CLTS MCO):** The benefit package includes assisted living services, which are residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health regulations 7.8.2 NMAC, *Residential Health Facilities*.

C. **Community transition goods and services, and community relocation specialist services (CLTS MCO):** The benefit package includes community transition and relocation specialist services designed to move individuals, where appropriate, from an institutional setting to home and community-based programs, as detailed in the coordinated long-term services contract.

D. **Emergency response services (CLTS MCO):** The benefit package includes emergency response services, including the provision of an electronic device that enables members to secure help in an emergency. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's telephone and programmed to signal a response center when the "help" button is activated. The response center must be staffed by trained professionals. Emergency response services include installing, testing and maintaining equipment; training members, caregivers and first responders on the use of the equipment; 24-hour monitoring for alarms; checking systems monthly, or more frequently, if warranted by electrical outages, severe weather or other conditions; and reporting member emergencies and changes in the member's condition that may affect service delivery. Emergency categories consist of emergency response, emergency response high need, and emergency response installation/disconnect.

E. **Environmental modifications (CLTS MCO):** The benefit package includes environmental modifications, including the purchase and/or installation of equipment and/or the making of physical adaptations to a member's residence that are necessary to ensure the health, welfare and safety of the member, or to enhance the member's level of independence.

(1) Adaptations include: installing ramps and grab-bars; widening doorways/hallways; installing specialized electric and plumbing systems to accommodate medical equipment and supplies; installing lifts or elevators; modifying bathroom facilities; adapting turnaround spaces; making specialized accessibility and safety adaptations; making household additions; installing trapeze and mobility tracks for home ceilings; installing automatic door openers and doorbells; installing voice, light or motion-activated electronic devices; making fire safety adaptations; installing air filtering devices; making heating/cooling adaptations; installing glass substitutes for windows and doors; installing modified switches, outlets or environmental controls for home devices; and installing alarm and alert systems and/or signaling devices.

(2) All environmental modifications shall be provided in accordance with applicable federal and state laws and regulations, and local building codes. The CLTS MCO must ensure that proper design criteria is used in planning and designing the adaptation; provide or secure licensed contractor(s) or approved vendor(s) to provide construction/remodeling services; provide administrative and technical oversight of construction projects; provide consultants to family members, waiver providers, and contractors concerning environmental modification projects; and inspect the final environmental modification project to ensure that the adaptations meet the approved plan.

F. **Private duty nursing services (CLTS MCO):** The benefit package includes private duty nursing services, including activities, procedures and treatment for a physical condition, physical illness or chronic disability. Services include: medication management, administration and teaching; aspiration precautions; feeding tube management; gastrostomy and jejunostomy; skin care; weight management; urinary catheter management; bowel and bladder care; wound care; health education; health screening; infection control; environment management for safety; nutrition management; oxygen management; seizure management and precautions; anxiety reduction; staff supervision; and behavior and self-care assistance.

G. **Respite services (CLTS MCO):** The benefit package includes respite services provided to members who are unable to care for themselves. Respite services are provided on a short-term basis because of the absence or need for relief of those persons normally providing the services. Respite services may be provided in a member's home or in the community. Services include: assistance with routine activities of daily living (e.g., bathing, toileting, preparing or assisting with meal preparation, and eating); enhancing self-help skills; providing opportunities for leisure, play and other recreational activities; and allowing community integration.

H. **Skilled maintenance therapy services (CLTS MCO):** The benefit package includes skilled maintenance therapy services, including occupational, physical and speech language therapy services.
[8.307.7.11 NMAC – N, 8-1-08]

8.307.7.12 BEHAVIORAL HEALTH SERVICES: Behavioral health services provided by the CLTS MCO's network providers will be covered by the CLTS MCO, even when the primary diagnosis is a behavioral health diagnosis. Facility costs, including emergency room costs, will be covered by the CLTS MCO unless there is a specific psychiatric revenue code on the facility claim form. Any professional services provided by a behavioral health service provider in an emergency room or in an inpatient or outpatient hospital setting will be covered by the SE. Any services provided by a physical health service provider in an emergency room or in an inpatient setting will be covered by the CLTS MCO. The SE will cover outpatient hospital services that require the use of a psychiatrist or psychologist revenue code for billing. Pharmacy claims prescribed by a physical health service provider will be covered by the CLTS MCO.

8.307.7.13 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS AND CHILDREN. The SE shall cover the following medicaid services. If, at any time, other medicaid behavioral health services are included in the state plan or a state plan amendment, the SE shall cover those services also.

A. **Inpatient hospital services:** The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC, *Hospital Services*.

B. **Hospital outpatient services:** The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt units of general hospitals as detailed in 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization.*

C. **Outpatient health care professional services:** The benefit package includes outpatient health care services, as detailed in 8.310.8 NMAC, *Mental Health Professional Services*.

D. **Comprehensive community support services:** The benefit package includes comprehensive community support services as detailed in 8.315.6 NMAC, *Comprehensive Community Support Services.*

E. **Assertive community treatment services (ACT):** The benefit package includes assertive community treatment services for members eighteen (18) years of age and older as detailed in 8.315.5 NMAC, Assertive Community Treatment Services.

[8.305.7.13 NMAC - Rp 8.305.7.13 NMAC, 7-1-04; A, 7-1-05; A, 7-1-08]

8.307.7.14 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE CLTS BENEFIT PACKAGE FOR CHILDREN ONLY: The SE shall provide the following medicaid services. The benefit package includes prevention, screening, diagnostic, ameliorative services and other medically necessary behavioral health care and substance abuse treatment or services for medicaid members under 21 years of age whose need for behavioral health services is identified by a licensed health care provider or during an EPSDT screen. All behavioral health care services shall be provided in accordance with the current New Mexico Children's Code and the Children's Mental Health and Developmental Disabilities Act, NMSA Section 32A-6-1 to 32A-6-22. The services include the following:

A. **Inpatient hospitalization in free standing psychiatric hospitals:** The benefit package includes inpatient services in free standing psychiatric hospitals as detailed in 8.321.2 NMAC, *Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals*.

B. **Accredited residential treatment center services:** The benefit package includes accredited residential treatment services as detailed in 8.321.3 NMAC, *Accredited Residential Treatment Center Services*.

C. **Nonaccredited residential treatment centers and group homes:** The benefit package includes residential treatment services as detailed in 8.321.4 NMAC, *Non-Accredited Residential Treatment Centers and Group Homes*.

D. **Treatment foster care:** The benefit package includes treatment foster care services as detailed in 8.322.2 NMAC, *Treatment Foster Care*.

E. **Treatment foster care II:** The benefit package includes treatment foster care II, as detailed in 8.322.5 NMAC, *Treatment Foster Care II*.

F. **Outpatient and partial hospitalization services in freestanding psychiatric hospital:** The benefit package includes outpatient and partial hospitalization services provided in freestanding psychiatric hospitals, as detailed in 8.321.5 NMAC, *Outpatient and Partial Hospitalization Services in Freestanding Psychiatric Hospitals*.

G. **Day treatment services:** The benefit package includes day treatment services, as detailed in 8.322.4 NMAC, *Day Treatment Services*.

H. **Behavior management skills development services (BMSDS):** The benefit package includes behavior management services, as detailed in 8.322.3 NMAC, *Behavior Management Skills Development Services.*

I. **School-based services:** The benefit package includes counseling, evaluation and therapy furnished in a school-based setting, but not when specified in the individual education plan (IEP) or the individualized family service plan (IFSP), as detailed in 8.320.6 NMAC, *School-Based Services for Recipients under 21 Years of Age*.

J. **Licensed alcohol and drug abuse counselors:** The benefit package includes alcohol and drug abuse counseling, as detailed in 8.323.3 NMAC, *Licensed Alcohol and Drug Abuse Counselors*.

K. **Multi-systemic therapy services:** The benefit package includes multi-systemic therapy services, as detailed in 8.322.6 NMAC, *Multi-Systemic Therapy Services.*

[8.305.7.14 NMAC - Rp 8.305.7.14 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-08]

8.307.7.15 BEHAVIORAL HEALTH SERVICES INCLUDED IN THE BENEFIT PACKAGE FOR ADULTS ONLY: The benefit package includes psychosocial rehabilitation, as detailed in 8.315.3 NMAC Psychosocial Rehabilitation Services, and shall be provided by the SE, in accordance with the New Mexico Mental Health and Developmental Disabilities Code, NMSA Sections 43-1-1 to 43-1-25.
[8.305.7.15 NMAC - Rp 8.305.7.15 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-08 – N, 8-1-08]

8.307.7.16 SERVICES EXCLUDED FROM THE CLTS BENEFIT PACKAGE: The following services are not included in the coordinated long-term services program benefit package:

A. services provided in intermediate care facilities for the mentally retarded (ICF/MR), as set forth in 8.313.2 NMAC, *Intermediate Care Facilities for the Mentally Retarded*;

B. emergency services to undocumented aliens, as set forth in 8.325.10 NMAC, *Emergency Services for Undocumented Aliens*;

C. experimental or investigational procedures, technologies or non-drug therapies, as set forth in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Non-Drug Therapies*;

D. case management services provided by the children, youth and families department that are defined as child protective services case management, as set forth in 8.320.5 NMAC, *EPSDT Case Management*;

E. case management services provided by the aging and long-term services department, as set forth in 8.326.7 NMAC, *Adult Protective Services Case Management*;

F. case management services provided by the children, youth and families department, as set forth in 8.326.8, *Case Management Services for Children Provided by Juvenile Probation and Parole Officers*;

G. services provided in the schools and specified in the IEP or IFSP, as set forth in 8.320.6 NMAC, *School-Based Services for Recipients Under 21 Years of Age*; and

H. services provided under the home and community-based waiver services programs, as set forth in MAD 733 NMAC, *Home and Community-Based Services Waivers*, the medically fragile waiver, HIV/AIDS waiver, developmentally disabled waiver, and *Mi Via* waiver.

[8.307.7.13 NMAC – N, 8-1-08]

8.307.7.17 VALUE-ADDED SERVICES: See 8.307.17 NMAC.
[8.307.7.14 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 8 QUALITY MANAGEMENT

8.307.8.1 ISSUING AGENCY: Human Services Department
[8.307.8.1 NMAC – N, 8-1-08]

8.307.8.2 SCOPE: This rule applies to the general public.
[8.307.8.2 NMAC – N, 8-1-08]

8.307.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute.
[8.307.8.3 NMAC – N, 8-1-08]

8.307.8.4 DURATION: Permanent
[8.307.8.4 NMAC – N, 8-1-08]

8.307.8.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.8.5 NMAC – N, 8-1-08]

8.307.8.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.8.6 NMAC – N, 8-1-08]

8.307.8.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.8.7 NMAC – N, 8-1-08]

8.307.8.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.8.8 NMAC – N, 8-1-08]

8.307.8.9 QUALITY MANAGEMENT: The human services department (HSD) recognizes that strong programs of quality improvement (QI) and assurance help ensure that better services are delivered in a cost-effective manner to the member. Under the terms of the medicaid coordinated long-term services contract, quality management (QM) programs are incorporated into health service delivery and administrative systems.
[8.307.8.9 NMAC – N, 8-1-08]

8.307.8.10 EXTERNAL QUALITY REVIEW: The state shall retain the services of an external quality review organization (EQRO) in accordance with the Social Security Act §1902(a)(30)(C). The coordinated long-term services managed care organizations (CLTS MCOs) shall cooperate fully with the EQRO and demonstrate adherence to HSD's regulations and quality standards. The EQRO shall not be a competitor of the CLTS MCO. The CLTS MCO shall utilize technical assistance and guidelines offered by the EQRO, when recommended or directed by the state.
[8.307.8.10 NMAC – N, 8-1-08]

8.307.8.11 BROAD STANDARDS:

A. **HEDIS requirement:** The CLTS MCO shall submit a copy of its audited health plan employer data and information set (HEDIS) data submission tool to HSD or its designee at the same time it is submitted to NCQA. The CLTS MCO is expected to use and rely upon HEDIS data as an important measure of performance for HSD. The CLTS MCO is expected to incorporate the results of each year's HEDIS data submission into its QI/QM plan. The results of the CLTS MCO's HEDIS ® Compliance Audit ™ shall accompany its data submission tool.

B. **Mental health reporting requirement:** The SE shall be responsible for the collection and submission of a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey for both the medicaid adult and child family population as an annual reporting requirement. The SE shall adhere to the established HSD survey administration and reporting process. The annual C/FSP shall also include non-survey

indicators defined by HSD as part of this reporting requirement for each contract calendar year. The SE shall report the C/FSP data set and any additional HSD requested data that are similar to that of C/FSP to HSD annually each fiscal year. The SE shall submit to HSD a written analysis of the annual C/FSP report based on the aggregate survey data results for both the child/family and adult populations.

C. **Collection of clinical data:** For indicators requiring clinical data as a data source, the CLTS MCO shall collect and utilize a sample of clinical records sufficient to produce statistically valid results. The size of the sample shall support stratification of the population by a range of demographic and clinical factors pertinent to the special vulnerable populations served. These populations shall include, but are not limited to, ethnic minorities, homeless, pregnant women, gender and age-based populations.

D. **Behavioral health data (SE only):** For reporting purposes, BH data shall be collected and reported for any medicaid managed care member receiving any behavioral health service provided by a licensed or certified behavioral health practitioner, regardless of setting or location as required by HSD. This includes behavioral health licensed professionals, practicing within the SE. The SE shall monitor and ensure the integrity of data. Findings shall be reported to HSD upon request.

E. **Provision of emergency services:** The CLTS MCO shall ensure that acute general hospitals are reimbursed for emergency services, which they will provide because of federal mandate, such as the "anti-dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. §1395dd. (1867 of the Social Security Act).

E. **Disease reporting:** The CLTS MCO shall require its service providers to comply with disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

H. The CLTS MCO agrees to comply with all applicable standards, orders and regulations issued pursuant to the Clean Air Act, 42 U.S.C. §7401 et. seq., and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. §1251 et. seq. In addition to any and all remedies or penalties set forth in this agreement, any violation of this provision shall be reported to the US department of health and human services (HHS) and the appropriate regional office of the environmental protection agency.

[8.307.8.11 NMAC – N, 8-1-08]

8.307.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** Quality management (QM) is an integrated approach that links knowledge, structure and processes together throughout the CLTS MCO/SE's system to assess and improve quality. The goal of quality improvement (QI) activities is to improve the quality of clinical care and services provided to members in the areas of health service delivery and supportive administrative systems. The CLTS MCO /SE's QM and QI structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements. Responsibilities shall be assigned to appropriate individuals. The CLTS MCO/SE shall submit its comprehensive QM/QI plan for the coming year on an annual basis, as well as a comprehensive QM/QI evaluation of the previous year's achievement and performance of its QM/QI goals and initiatives. The QI program for the CLTS MCO/SE shall be reviewed and approved by HSD or its designee annually. The CLTS MCO/SE's QI/QM activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review annual evaluation; opportunities for improvement identified through either the annual HEDIS indicators or state defined performance measures; the annually required consumer satisfaction surveys and service provider surveys; and any findings identified by an accreditation body such as NCQA.

(1) The QM/QI program shall include: specific targeted goals, objectives and structures that cover the CLTS MCO/SE's immediate objectives for each contract year or calendar year; and long-term objectives for the entire contract period. The annual plan shall include the specific interventions to be utilized to improve the quality targets, as well as the timeframes for evaluation.

(2) The QM/QI program shall be accountable to the governing body that reviews and approves the QM/QI program.

(3) The program description shall specify the roles, authority and responsibilities of a designated physician/psychiatrist in the QM/QI program.

(4) A quality-related committee shall oversee and be involved in QI activities.

(5) The program description shall specify the role of the QI committee and subcommittees, including any committees dealing with oversight of delegated activities.

(6) The program description shall describe QI committee composition, including CLTS MCO/SE service providers, committee member selection policies, and roles and responsibilities.

(7) The program description shall include: the committee functions, including policy recommendations; review/evaluation of QI activities; institution of needed actions; follow-up of instituted actions; and contemporaneous documentation of committee decisions and actions.

(8) The program description shall address QI for all major demographic groups within the CLTS MCO or SE.

(9) The program description shall address member satisfaction and include methods of collecting and evaluating information, including the consumer assessment of health plans survey (CAHPS), a survey identifying opportunities for improvement, implementing and measuring effectiveness of intervention, and informing service providers of results.

(10) The program description/work plan shall address the process by which the CLTS MCO/SE adopts, reviews at least every two years, and appropriately updates and disseminates evidence-based clinical practice guidelines for the provision of services for acute and chronic conditions, including behavioral health (SE only). The CLTS MCO/SE shall involve its service providers in this process.

(11) The program description/work plan shall address activities aimed at addressing culture-specific health beliefs and behaviors and risk conditions, and shall respond to member and service provider requests for culturally appropriate services. Culturally appropriate services may include: language and translation services, dietary practices, individual and family interaction norms, and the role of the family in compliance with long-term treatment.

(12) The program description/work plan shall address activities to improve the health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing service providers about the programs and services for members assigned to them.

(13) The program description/work plan shall address activities that ensure continuity and coordination of care, including physical and behavioral health services, collection and analysis of data, and appropriate interventions to improve coordination and continuity of care.

(14) The program description/work plan shall include specific activities that facilitate continuity and coordination of physical and behavioral health care. The responsibility for these activities shall not be delegated.

(15) The program description/work plan shall include: objectives for the year; activities regarding quality of clinical care and services; timelines; responsible persons; planned monitoring for newly identified and previously identified issues; and an annual evaluation of the QI program.

(16) The program description shall include means by which the CLTS MCO/SE shall communicate quality improvement results to its members and service providers.

(17) The QI program personnel and information resources shall be adequate to meet program needs and devoted to and available for QI activities.

(18) The QM/QI annual written evaluation submitted to HSD shall include a review of completed and continuing QI activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service; and evaluation of the overall effectiveness of the QI program based on evidence of meaningful improvements (See Subsection J of 8.307.8.12 NMAC, *Effectiveness of the QI Program*).

(19) The program description/work plan shall include specific activities related to findings identified in the annual consumer and service provider surveys as areas that indicate targeted QI interventions and monitoring.

B. **Program operations:** The QI committee shall:

(1) recommend QI policy reviews, evaluate the results of QI activities, institute needed actions, and ensure follow-up as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all QI committee decisions and actions;

(3) ensure that the CLTS MCO/SE's service providers participate actively in the QI activities;

(4) ensure that the CLTS MCO/SE coordinates the QM/QI program with performance monitoring activities throughout the organization, including, but not limited to: utilization management; fraud and abuse detection; credentialing; monitoring and resolution of member grievances and appeals; assessment of member satisfaction; and medical records review;

(5) ensure that there is a linkage between the QM/QI program and other management activities, such as network changes, benefits redesign, practice feedback to service providers, member health education, and member services, which will be documented in progress reports submitted to HSD or its designee;

(6) ensure that there is evidence that the results of QI activities, performance improvement projects and reviews are used to improve quality. There will be evidence of communication and use of the results of QI

activities, performance improvement projects and reviews, with appropriate individual and institutional service providers;

(7) ensure that the CLTS MCO/SE coordinated the QI program with performance monitoring activities throughout the organization, including but not limited to, its compliance with all quality standards and other specifications in the contract for medicaid coordinated long-term services, such as compliance with state standards;

(8) ensure that the CLTS MCO/SE's QM/QI program is applied to the entire range of health services provided through the CLTS MCO/SE by assuring that all major population groups, service settings and types of service are included in the scope of the review. A major population or prevalent group is one that represents at least 5% of a CLTS MCO/SE's enrollment; and

(9) ensure that stakeholders/members have an opportunity to provide input.

C. **Health services contracting:** Contracts with individual and institutional service providers shall specify that contractors cooperate with the CLTS MCO/SE's QM/QI program.

D. **Continuous quality improvement/total quality management:** The CLTS MCO/SE shall ensure that clinical and nonclinical aspects of its quality management program are based on principles of continuous quality improvement/total quality management (CQI/TQM). Such an approach shall include at least the following:

(1) recognition that opportunities for improvement are unlimited;

(2) assurance that the QI process is data driven;

(3) use of member and service provider input; and

(4) require ongoing measurement of clinical and non-clinical effectiveness and programmatic improvements.

E. **Member satisfaction:** The CLTS MCO/SE shall implement methods aimed at member satisfaction with the active involvement and participation of members and their families, whenever possible.

(1) The CLTS MCO shall conduct and submit to HSD as part of its HEDIS reporting requirements, an annual survey of member satisfaction (CAHPS or latest version of adult and child instruments). The SE, in accordance with the requirement for the annual consumer satisfaction survey, will submit the C/FSP analysis report to HSD and utilize its results in the following year's quality initiatives;

(2) The CLTS MCO shall use the medicare health outcomes survey to assess issues related to physical and behavioral health status;

(3) The CLTS MCO/SE shall add questions about individuals with special health care needs (ISHCN) to all consumer surveys, as appropriate;

(4) The CLTS MCO/SE shall disseminate results of the member satisfaction survey to service providers, providers, the state, and CLTS MCO/SE members;

(5) The CLTS MCO shall cooperate with the state in conducting a network provider satisfaction survey;

(6) The CLTS MCO/SE shall evaluate member grievances and appeals for trends and specific problems, including behavioral health problems;

(7) The CLTS MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement in the quality of CLTS MCO/SE performance;

(8) The CLTS MCO/SE shall implement interventions to improve its performance;

(9) The CLTS MCO/SE shall measure the effectiveness of the interventions; and

(10) The CLTS MCO shall participate in the design of specific questions for the CAHPS adult and child surveys.

F. **Health management systems:**

(1) The CLTS MCO/SE shall actively work to improve the health status of its members with chronic physical and behavioral health conditions, utilizing best practices throughout its provider networks. Additionally, the CLTS MCO/SE shall implement policies and procedures for coordinating care between their respective organizations.

(a) The CLTS MCO shall proactively identify members with chronic medical conditions, and offer appropriate outreach, services and programs to assist in managing and improving their chronic conditions. The SE shall proactively identify members with chronic behavioral health (both mental health and substance abuse) conditions, including co-occurring disorders, and offer appropriate outreach, services and programs to assist in managing and approving their chronic behavioral health conditions;

(b) The SE shall proactively identify the unduplicated number of adult severally disabled mentally ill (SDMI) and sever emotionally, behaviorally and neurobiologically disturbed children (SED) and chronic substance abuse (CSA) members served, including those with co-occurring mental health and substance

abuse disorders.

(c) The CLTS MCO/SE shall report the following adverse events involving SDMI, SED, CSA, and co-occurring mental health and substance abuse member to HSD on a monthly basis: suicides, attempted suicides, involuntary hospitalizations, detentions for protective custody, and detentions for alleged criminal activity utilizing reporting template provided by HSD or its designee. The SE shall utilize HSD's definitions for the identification of these categories of behavioral members for standardization purposes;

(d) The CLTS MCO/SE shall proactively identify ISHCN who have or are at increased risk for a chronic physical or behavioral health condition;

(e) The CLTS MCO/SE shall inform and educate its service providers about the use of health management programs for CLTS MCO/SE members;

(f) The CLTS MCO/SE shall participate with service providers to reduce the inappropriate use of psychopharmacological medications and adverse drug reactions; and

(g) The CLTS MCO/SE shall periodically update its service providers regarding best practices and on procedures for appropriate health service referrals.

(2) The CLTS MCO/SE shall pursue continuity of services for members. The CLTS MCO/SE shall:

(a) report changes in its provider network to HSD or its designee;

(b) have a defined health service delivery process to promote a high level of member compliance with follow-up appointments, consultations/referrals, and diagnostic laboratory, diagnostic imaging and other testing;

(c) have a defined process to ensure prompt member notification by its service providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and this will be documented in the medical record;

(d) ensure that the processes for follow-up visits, consultations and referrals are consistent with high quality care and service and do not create a clinically significant impediment to timely medically necessary services. The determination of medical necessity shall be based on HSD's medical necessity definition and its application;

(e) ensure that all medically necessary referrals are arranged and coordinated by either the referring service provider or by the CLTS MCO/SE's service coordination unit;

(f) implement policies and procedures to ensure that continuity and coordination of services occur across practices, service provider sites and between CLTS MCO/SE. In particular, the CLTS MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as the department of health, the children youth and families department protective services and juvenile justice divisions, the corrections department community reentry services, and the schools. In additions, the SE shall coordinate services with all applicable state agencies comprising the collaborative; and

(g) assist and monitor the transitions between service providers for continuity of services in order to avoid abrupt changes in treatment plans and caregivers for members currently being served.

(3) At the request of a member or their legal guardian, the CLTS MCO/SE shall provide information to consumer/participants on options for converting coverage to a different insurance to members whose enrollment is terminated due to loss of medicaid eligibility, and this shall be documented.

G. **Clinical practice guidelines:** The CLTS MCO/SE shall disseminate to service providers recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services.

(1) The CLTS MCO/SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of the medicaid populations.

(2) The clinical practice guidelines shall be evidence-based.

(3) The CLTS MCO/SE shall involve board certified service providers from its network who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

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

(5) The CLTS MCO/SE shall distribute the guidelines to the appropriate service providers and to HSD or its designee.

(6) The CLTS MCO/SE shall annually measure service provider performance against at least two important aspects of three clinical practice guidelines and determine consistency of decision-making based on the clinical practices guidelines.

(7) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

(8) The CLTS MCOs shall implement HSD-approved targeted disease management protocols and procedures for chronic diseases or conditions, such as asthma, diabetes, and hypertension that are appropriate to meet the needs of the varied medicaid populations. The SE shall implement targeted disease management protocols and procedures for chronic diseases or conditions, such as bipolar disorder, depression, and schizophrenia that are appropriate to meet the needs of the varied Medicaid populations. The CLTS MCO shall:

(a) improve the ability to manage chronic illnesses/diseases in order to meet goals based on jointly established targets;

(b) provide comprehensive disease management for a minimum of two (2) chronic diseases using strategies consistent with nationally recognized disease management guidelines,

(c) submit cumulative data-driven measurements from each of its disease management programs to the state according to contract requirements. All disease management data submitted to the state shall be new mexico medicaid-specific;

(d) submit to the state annually the CLTS MCO disease management plan, which includes a program description, overall program goals, measurable objectives, targeted interventions, and its methodology used to identify other diseases for potential disease management programs;

(e) submit to the state annually a quantitative evaluation of the efficacy of the prior year's disease management program; and

(f) demonstrate consistent improvement in the overall disease management program goals annually or maintain mutually agreed upon level of performance with a report to the state.

H. **Quality assessment and performance improvement:** The CLTS MCO/SE shall achieve required minimum performance levels, as established by HSD and the centers for medicare and medicaid services (CMS), on certain quality performance measures and projects. These required levels of performance would address a broad spectrum of key aspects of member care and services. These quality measures may change from year to year and may be used in part to determine the CLTS MCO/SE assignment algorithm. In addition, the CLTS MCO/SE shall provide HSD or its designee with copies of all studies performed for national accreditation. The CLTS MCO/SE shall achieve minimum performance levels set by HSD for each performance measure. The CLTS MCO/SE shall measure its performance, using claims, encounter data, and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD. The SE shall annually provide HSD with copies of its QM/QI studies including its data analysis. The CLTS MCO shall:

(1) implement performance measures and tracking measures defined by HSD or its designee in collaboration with the CLTS MCO. The CLTS MCO shall monitor these measures on an ongoing basis and report results to HSD or its designee;

(2) identify and monitor performance measures and tracking measures of home and community-based service delivery, and implement activities designed to improve the coordination of CLTS services;

(3) demonstrate consistent and sustainable patterns of improvement from year to year in the overall member satisfaction survey results, disease management initiatives and performance measures;

(4) review outcome data at least quarterly for performance improvement recommendations and interventions; and

(5) provide mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by network providers.

I. **Intervention and follow-up for clinical and service issues:** The CLTS MCO/SE shall have a process and take action to improve quality by addressing opportunities for improving performance identified through clinical and service QI activities, as appropriate, and shall also assess the effectiveness of the interventions through systematic follow-up. The CLTS MCO/SE shall:

(1) implement interventions to improve service provider and system performance as appropriate.

(2) implement appropriate corrective interventions when it identifies individual occurrences of poor or substandard quality, especially regarding health and safety issues.

(3) implement appropriate corrective interventions when it identifies underutilization or over-utilization.

J. **Effectiveness of the QI program:** The CLTS MCO/SE shall evaluate the overall effectiveness of its QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members.

(1) The CLTS MCO/SE shall perform an annual written evaluation of the QI program and provide a copy to HSD or its designee for CMS review. This evaluation shall include at least the following:

(a) a description of completed and ongoing QI activities;

(b) trending of measures to assess performance in quality of clinical care and quality of service;

(c) an analysis of whether there have been demonstrated improvements in the quality of clinical care and quality of service; and

(d) an evaluation of the overall effectiveness of the QI program.

(2) There shall be evidence that QI activities have contributed to meaningful improvement in the quality of clinical care and quality of service, including preventive health services, provided to members.
[8.307.8.12 NMAC – N, 8-1-08]

8.307.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented and activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under-utilization. The CLTS MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, that are congruent with HSD's medical necessity service definition as defined in 8.307.1 NMAC, *Definitions*, and are applied consistently in UM decisions by the CLTS MCO/SE. The CLTS MCO/SE's UM program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to manage the use of limited resources; maximize the effectiveness of services by evaluating clinical appropriateness; authorize the type and volume of services through fair, consistent and culturally competent decision making; and assure equitable access to services. These standards shall also apply to pharmacy utilization management including the formulary exception process.

A. **Program design:**

(1) A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the CLTS MCO and entities to which the CLTS MCO/SE delegates UM activities.

(2) A designated physician shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate service coordination, discharge criteria, site of services, levels of care, triage decisions and cultural competence of service delivery; processes to review, approve and deny services; processes to evaluate service outcomes; and a plan to improve outcomes, as needed. The above service definitions are to be no less than the amount, duration and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230. The member's individualized service plan (ISP) priorities and prolonged service authorizations applicable for individuals with chronic conditions shall be considered in the decision-making process.

(4) The CLTS MCO/SE shall ensure that the services are sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished. The CLTS MCO/SE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the beneficiary's diagnosis, type of illness, or condition.

(5) The UM program shall be evaluated and approved annually by senior management and the medical director or the QI committee.

(6) The UM program shall include policies and procedures for monitoring inter-rater reliability of all individuals performing utilization review. The procedures shall include a monitoring and education process for all utilization review staff identified as not meeting 90% agreement on test cases, until adequately resolved.

B. **UM decision criteria:** To make utilization decisions, the CLTS MCO/SE shall use written utilization review decision criteria that are based on reasonable medical evidence, consistent with the New Mexico medicaid definition for medically necessary services, and that are applied in a fair, impartial and consistent manner to serve the best interests of all members.

(1) UM decisions shall be based on reasonable and scientifically valid utilization review criteria that are objective and measurable, insofar as practical.

(2) The criteria for determining medical necessity shall be academically defensible; based on national standards of practice when such standards are available; involve appropriate service providers when developing, adopting and reviewing criteria; and acceptable to the CLTS MCO/SE's medical (or behavioral health) director, peer consultants and relevant local providers. The CLTS MCO/SE shall specify what constitutes medically necessary services in a manner that is no more restrictive than that used by HSD as indicated in state statutes and regulations. According to this definition, the CLTS MCO/SE must be responsible for covered services related to the following:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

(3) Criteria for determination of medical appropriateness shall be clearly documented.

(4) The CLTS MCO/SE shall maintain evidence that it has reviewed the criteria at specified intervals and that the criteria have been updated, as necessary.

(5) The CLTS MCO/SE shall state in writing how service providers can obtain UM criteria and shall provide criteria to its service providers upon request.

C. **Authorization of services:** For the processing of requests for initial and continuing authorization of services, the CLTS MCO/SE shall:

(1) have a policy and procedure in place for authorization decisions;

(2) require that its subcontractors have in place written policies and procedures;

(3) have in effect a mechanism to ensure consistent application of review criteria for authorization decisions;

(4) consult with requesting providers when appropriate to secure additional information.

D. **Use of qualified professionals:** The CLTS MCO/SE shall have written policies and procedures explaining how qualified health professionals shall assess the clinical information used to support UM decisions.

(1) Appropriately licensed and experienced health care service providers whose education, training, experience and expertise are commensurate with the UM reviews conducted shall supervise review decisions.

(2) Denials based on medical necessity shall be made by a designated physician for the UM program. The reason for the denial shall be cited.

(3) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the CLTS MCO/SE shall approve the appropriate level of care as well as deny that which was determined to be inappropriate.

(4) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting service provider responsible for justifying the medical necessity.

E. **Timeliness of decisions and notifications:** The CLTS MCO/SE shall make utilization decisions and notifications in a timely manner that accommodate the clinical urgency of the situation and minimize disruption in the provision and continuity of health care services. The following timeframes are required and shall not be affected by "pend" decisions.

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) services, the CLTS MCO/SE shall make a decision within 14 calendar days from receipt of request for service.

(b) **Notification:** For authorization or denial of non-urgent (routine) services, the CLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) services, the CLTS MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision.

(2) **Precertification - urgent:**

(a) **Decision and notification:** For precertification of urgent services, the CLTS MCO/SE shall make a decision and notify the service provider of the decision within 72 hours of receipt of request. For authorization of urgent services that result in a denial, the CLTS MCO/SE shall notify both the member and service provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent services, the CLTS MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision. The CLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(3) **Precertification – residential services (SE only):** For precertification of RTC, TFC and group home, the SE shall make a decision within five (5) working days from receipt of request of services.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent services, a 14 calendar day extension may be requested by the member or service provider. A 14 calendar day extension may also be requested by the CLTS MCO/SE. The CLTS MCO/SE must justify in the UM file the need for additional information and that the 14 day extension is in the member's interest.

(5) **Concurrent - routine:**

(a) **Decisions:** For concurrent review of routine services, the CLTS MCO/SE shall make a decision within 10 working days of the receipt of the request.

(b) **Notification:** For authorization or denial of routine continued stay, the CLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the CLTS MCO/SE shall give

the member and service provider written or electronic confirmation within one working day of the decision. The CLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(6) **Concurrent - urgent:**

(a) **Decision:** For concurrent review of urgent services, the CLTS MCO/SE shall make a decision within one working day of receipt of request.

(b) **Notification:** For authorization or denial of urgent continued stay, the CLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision. The CLTS MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the CLTS MCO/SE shall give the member and service provider written or electronic confirmation within one working day of the decision. The CLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(7) **Concurrent-residential services (SE only):** For concurrent reviews of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service. Timelines for routine and urgent concurrent shall apply.

(8) **Administrative/technical denials:** When the CLTS MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to service provider noncompliance with the CLTS MCO/SE's administrative policies, the CLTS MCO/SE shall adhere to the timelines cited above for decision making, notification and written confirmation.

F. **Use of clinical information:** When making a determination of coverage based on medical necessity, the CLTS MCO/SE shall obtain relevant clinical information and consult with the treating service provider, as appropriate.

(1) A written description shall identify the information required and collected to support UM decision making.

(2) A thorough assessment of the member's needs based on clinical appropriateness and necessity shall be performed.

(3) There shall be documentation that relevant clinical information is gathered consistently to support UM decision making. The CLTS MCO/SE UM policies and procedures will clearly define in writing for service providers what constitutes relevant clinical information, as well as how to accurately submit authorization requests.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating service providers.

G. **Denial of services:** A "denial" is a nonauthorization of a request for care or services. The CLTS MCO/SE shall clearly document in the UR file a reference to the specific provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

(1) The CLTS MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the CLTS MCO/SE medical director.

(2) The CLTS MCO/SE shall make available to a requesting service provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

(3) The CLTS MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the service provider, as appropriate.

(4) The CLTS MCO/SE shall recognize that a utilization review decision made by the designated HSD official resulting from a fair hearing is final and shall be honored by the CLTS MCO/SE, unless the CLTS MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each CLTS MCO/SE contract must provide that, consistent with 42 CFR §§438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

I. **Evaluation and use of new technologies:** The CLTS MCO/SE and its delegates shall evaluate the inclusion of new medical technology and the new applications of existing technology in the benefit package. This includes the evaluation of clinical procedures and interventions, drugs and devices.

(1) The CLTS MCO/SE shall have a written description of the process used to determine whether new medical technology and new uses of existing technologies shall be included in the benefit package.

(a) The written description shall include the decision variables used by the CLTS MCO/SE to

evaluate whether new medical technology and new applications of existing technology shall be included in the benefit package.

(b) The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

(c) Appropriate professionals shall participate in the process to decide whether to include new medical technology and new uses of existing technology in the benefit package.

(2) A CLTS MCO/SE shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of "experimental, investigational or unproven" contained in 8.325.6 NMAC.

J. **Evaluation of the UM process:** The CLTS MCO/SE shall evaluate member and service provider satisfaction with the UM process based on member and service provider satisfaction survey results. The CLTS MCO/SE shall forward the evaluation results to HSD or its designee.

K. **HSD access:** HSD or its designee shall have access to the CLTS MCO/SE's UM review documentation on request.

[8.307.8.13 NMAC – N, 8-1-08]

8.307.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The CLTS MCO/SE shall document the mechanism for credentialing and recredentialing of service providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of service providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions that may not be discriminatory, and the extent of delegated credentialing or recredentialing arrangements. The credentialing process shall be completed within 180 days from receipt of completed application with all required documentation unless there are extenuating circumstances.

A. **Service provider participation:** The CLTS MCO/SE shall have a process for receiving input from participating service providers regarding credentialing and recredentialing of service providers.

B. **Primary source verification:** At the time of credentialing the service provider, the CLTS MCO/SE shall verify the following information from primary sources:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the service provider as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of service providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the service provider;

(5) board certification if the service provider states on the application that the service provider is board certified in a specialty; and

(6) current, adequate malpractice insurance, according to the CLTS MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The CLTS MCO/SE shall use the HSD-approved credentialing form. The service provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. **External source verification:** Before a service provider is credentialed, the CLTS MCO/SE shall receive information on the service provider from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the service provider type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;
(c) state board of dental examiners;
(d) state board of podiatric examiners;
(e) state board of nursing;
(f) the appropriate state licensing board for other service provider types, including behavioral health; and
(g) other recognized monitoring organizations appropriate to the service provider's discipline.

(3) sanctions by medicare and medicaid, as applicable.

E. **Evaluation of service provider site and medical records.** At the time of credentialing the CLTS MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists. The SE shall perform an initial visit to the offices of potential high volume behavioral health care service providers, prior to acceptance and inclusion as participating service providers. The CLTS MCO/SE shall determine its method for identifying high volume behavioral health service providers.

(1) The CLTS MCO/SE shall document a structured review to evaluate the site against the CLTS MCO/SE's organizational standards and those specified by the coordinated long-term services contract.

(2) The CLTS MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the CLTS MCO/SE's organizational standards.

F. **Recredentialing:** The CLTS MCO/SE shall have formalized recredentialing procedures.

(1) The CLTS MCO/SE shall formally recredential its service providers at least every three years. During the recredentialing process the CLTS MCO/SE shall verify the following information from primary sources:
(a) a current valid license to practice;
(b) the status of clinical privileges at the hospital designated by the service provider as the primary admitting facility;
(c) valid DEA or CSR certificate, if applicable;
(d) board certification, if the service provider was due to be recertified or became board certified since last credentialed or recredentialed;
(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and
(f) a current, signed attestation statement by the applicant regarding:
(i) ability to perform the essential functions of the position, with or without accommodation;
(ii) lack of current illegal drug use;
(iii) history of loss or limitation of privileges or disciplinary action; and
(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the CLTS MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:
(a) the national practitioner data bank;
(b) medicare and medicaid;
(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;
(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;
(e) state board of dental examiners;
(f) state board of podiatric examiners;
(g) state board of nursing;
(h) the appropriate state licensing board for other service provider types; and
(i) other recognized monitoring organizations appropriate to the service provider's discipline.

(3) The CLTS MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for service providers:
(a) member grievances and appeals;
(b) information from quality management and improvement activities; and
(c) medical record reviews conducted under Subsection E of 8.307.8.14 NMAC.

G. **Imposition of remedies:** The CLTS MCO/SE shall have policies and procedures for altering the conditions of the service provider's participation with the CLTS MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the CLTS MCO/SE may take to improve the service provider's performance prior to termination.

(1) The CLTS MCO/SE shall have procedures for reporting to appropriate authorities, including HSD

or its designee, serious quality deficiencies that could result in a service provider's suspension or termination.

(2) The CLTS MCO/SE shall have an appeal process by which the CLTS MCO/SE may change the conditions of a service provider's participation based on issues of quality of care and service. The CLTS MCO/SE shall inform service providers of the appeal process in writing.

H. **Assessment of organizational providers:** The CLTS MCO/SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. Service providers include, but are not limited to, hospitals, home health agencies, nursing facilities, assisted living facilities, free-standing surgical centers, behavioral, psychiatric and addiction disorder facilities or services, residential treatment centers, clinics, 24-hour programs, behavioral health units of general hospitals and free-standing psychiatric hospitals. At least every three years, the CLTS MCO/SE shall confirm that the service provider is in good standing with state and federal regulatory bodies, including HSD, and has been accredited or certified by the appropriate accrediting body and state certification agency or has met standards of participation required by the CLTS MCO/SE.

(1) The CLTS MCO/SE shall confirm that the service provider has been certified by the appropriate state certification agency, when applicable. Behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification.

(2) The CLTS MCO/SE shall confirm that the service provider has been accredited by the appropriate accrediting body or has a detailed written plan that could reasonably be expected to lead to accreditation within a reasonable period of time. Behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.307.8.14 NMAC – N, 8-1-08]

8.307.8.15 MEMBER BILL OF RIGHTS: Under medicaid coordinated long-term services, members have certain rights and responsibilities and the CLTS MCO/SE shall have policies and procedures governing member rights and responsibilities. The following subsections shall be known as the "Member Bill of Rights".

A. **Members' rights:**

(1) Members shall have the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Members shall have the right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have the right to participate with their service providers in decision making in all aspects of their health services, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with service decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the CLTS MCO/SE network, or the CLTS MCO/SE shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian needs additional information regarding recommended treatment or believes the service provider is not authorizing requested services.

(8) Members or their legal guardians shall have a right to voice grievances about the services provided by the CLTS MCO/SE and to make use of the CLTS MCO/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have the right to choose from among the available service

providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have the right to make their wishes known through advance directives regarding health service decisions (e.g., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have the right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have the right to receive information about: the CLTS MCO/SE, its health care services, how to access those services, and the CLTS MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the CLTS MCO/SE or its network providers in regard to contractual disputes between the CLTS MCO/SE and providers.

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

(15) Members or their legal guardians shall have the right to select a CLTS MCO and exercise switch enrollment rights without threats or harassment.

B. **Standards for Consumer/Participant Direction**

(1) Members have direct involvement, control, and choice in assessing his/her own needs and identifying, accessing, and managing services and supports to meet those needs. When appropriate, families or representatives shall be involved in the process. In consumer/participant direction, the process shall also include a member's active participation in making key service plan and service priority decisions as well as evaluating the quality of the services rendered.

(2) CLTS MCO shall recognize a continuum of different levels of informed decision-making authority, control and autonomy, to the extent desired by the member, at any given point in the course of his/her participation in CLTS. These levels shall range from a member choosing not to direct his/her services and instead deferring to trusted family members or representatives of his/her choosing; and

(3) Ensure that a member can move across the continuum of decision-making, depending upon his/her needs and circumstances, and shall support the member in his/her decision regarding the level of consumer/participant direction chosen.

C. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have the responsibility to provide, whenever possible, information that the CLTS MCO/SE and service providers need in order to care for them.

(2) Members or their legal guardians shall have the responsibility to understand the member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have the responsibility to follow the plans and instructions for services that they have agreed upon with their service providers or to notify service providers if changes are requested.

(4) Members or their legal guardians shall have the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

D. **CLTS MCO/SE responsibilities:**

(1) The CLTS MCO/SE shall provide a member handbook to its members and to potential members who request the handbook. The CLTS MCO/SE shall publish in the member handbook the members' rights and responsibilities from the member bill of rights. CLTS MCO/SE shall honor the provisions set forth in the member bill of rights.

(2) The CLTS MCO/SE shall comply with the grievance resolutions process found in 8.307.12 NMAC, *CLTS MCO*/SE *Member Grievance System.*

(3) The CLTS MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the CLTS MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The CLTS MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the CLTS MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) requires no more than a two-minute wait except following mass enrollment periods;

(b) does not require a "touch-tone" telephone;

(c) allows communication with members whose primary language is not English or who are

hearing impaired; and

(d) is in operation 24 hours per day, seven days per week.

(5) The CLTS MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The CLTS MCO/SE shall protect the confidentiality of member information and records.

(a) The CLTS MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The CLTS MCO/SE's contracts with service providers shall explicitly state expectations about confidentiality of member information and records.

(c) The CLTS MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the CLTS MCO/SE of identifiable personal information to a person or agency outside the CLTS MCO/SE, except when release is required by law, state regulation, court order, HSD quality standards, or in the case of behavioral health, the collaborative.

(d) The CLTS MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The CLTS MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The CLTS MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the CLTS MCO/SE delegates member service activity, the CLTS MCO/SE shall retain responsibility for documenting CLTS MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to service providers within the CLTS MCO/SE network. The CLTS MCO/SE shall have written policies regarding the requirement for service providers to abide by federal and state law and New Mexico medicaid policies regarding informed consent specific to:

(a) the treatment of minors;

(b) adults who are in the custody of the state;

(c) adults who are the subject of an active protective services case with CYFD;

(d) children and adolescents who fall under the jurisdiction of CYFD; and

(e) individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations.

(9) The CLTS MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The CLTS MCO/SE shall ensure that its service providers and their facilities comply with the Americans with Disabilities Act.

(10) The CLTS MCO/SE shall provide a member handbook to its members or potential members who request the handbook, and it shall be accessible via the internet.

(11) The CLTS MCO/SE shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

(12) The CLTS MCO shall not restrict a member's right to choose a provider of family planning services.

(13) The CLTS MCO/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The CLTS MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the CLTS MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.307.8.15 NMAC – N, 8-1-08]

8.307.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The CLTS MCO shall follow current national standards for preventive health services including behavioral health preventive services. These standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the CLTS MCO under these standards shall be adopted, reviewed at least every two years,

updated when appropriate and disseminated to service provider and member. Unless a member refuses and the refusal is documented, the CLTS MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The CLTS MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access services.

A. **Initial assessment:** The CLTS MCO shall perform an initial assessment of the medicaid member's health service needs within 90 days of the date the member enrolls in the CLTS MCO. For this purpose, a member is considered enrolled at the lock-in date.

B. **Immunizations:** The CLTS MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health advisory committee on immunizations. The CLTS MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee.

C. **Screens:** The CLTS MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium, at a periodicity determined by the CLTS MCO.

(4) *Blood pressure measurement*: Members over age 18 shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia;* All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier conception, have more than one sex partner or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over nine lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the

American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The CLTS MCO shall operate tot-to-teen mandated early and periodic screening, diagnostic and treatment (EPSDT) services as outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within three months of enrollment lock-in, the CLTS MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards). The CLTS MCO shall encourage PCPs to assess for age, height and gender appropriate weight during EPSDT screens to detect and treat evidence of weight or obesity issues in children and adolescents.

(15) Members over age 21 must be screened to detect high risk for behavioral health conditions at their first encounter with a PCP after enrollment.

(16) The CLTS MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The CLTS MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The CLTS MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;

(2) benefits of physical activity;

(3) benefits of a healthy diet;

(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;

(5) prevention of motor vehicle injuries;

(6) prevention of household and recreational injuries;

(7) prevention of dental and periodontal disease;

(8) prevention of HIV infection and other sexually transmitted diseases;

(9) prevention of unintended pregnancies; and

(10) prevention or intervention for obesity or weight issues.

E. **Hot line:** The CLTS MCO/SE shall provide a toll-free clinical telephone hot line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and

(2) prediagnostic and post-treatment health care decision assistance based on symptoms.

F. **Health information line:** The CLTS MCO shall provide a toll-free line that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions; and

(2) preventive/wellness counseling.

G. **Family planning:** The CLTS MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and

(2) HIV and other sexually transmitted diseases and risk reduction practices.

H. **Prenatal care:** The CLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;

(2) prompt and easy access to obstetrical services, including an office visit with a service provider within three weeks of having a positive pregnancy test (laboratory or home) unless earlier service is clinically indicated;

(3) risk assessment of all pregnant members to identify high-risk cases for special management;

(4) counseling that strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;

(6) screening for determination of need for a post-partum home visit; and

(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.307.8.16 NMAC – N, 8-1-08]

8.307.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The CLTS MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, and be legible, current, detailed and organized to permit effective and confidential patient service and quality review.

(1) The CLTS MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The CLTS MCO/SE shall have medical record documentation standards that are enforced with its CLTS MCO/SE providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);

(b) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) service provider identification (author of entry);

(e) allergies and adverse reactions to medications;

(f) past medical history for patients seen two or more times;

(g) status of preventive services provided or at least those specified by HSD or its designee, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history including what has been effective and what has not, and why;

(j) identification of current problems;

(k) history of smoking, alcohol use and substance abuse;

(l) reports of consultations and referrals;

(m) reports of emergency services, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) For patients who receive two or more services from a behavioral health provider through the SE within a 12-month period, the documentation standards shall meet medicaid requirements and require that the following items also be included in the medical record in addition to the above:

(a) a mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The CLTS MCO/SE standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;

(b) plan of treatment;

(c) diagnostic tests and the results;

(d) drugs prescribed, including the strength, amount, directions for use and refills;

(e) therapies and other prescribed regimens and the results;

(f) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of the member's physical or behavioral health services.

B. **Review of records:** The CLTS MCO/SE shall have a process to systematically review service provider medical records to ensure compliance with the medical record standards. The CLTS MCO/SE shall institute improvement actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the CLTS MCO's primary care providers, obstetricians, and gynecologists.

(2) The CLTS MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site follow-up plans to increase compliance with the CLTS MCO/SE's established medical record standards and goals.

C. **Access to records:** The CLTS MCO/SE shall provide HSD or its designee appropriate access to service provider medical records.

(1) The CLTS MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all service providers involved in the member's services, to ensure continuity of services. The CLTS MCO shall ensure that service providers involved in the member's services have access to the member's primary medical record, including the SE, when necessary.

(2) The CLTS MCO/SE shall include provisions in its contracts with service providers for appropriate access to the CLTS MCO/SE's members' medical records for purposes of in-state quality reviews conducted by HSD or its designee, and for making medical records available to service providers, including behavioral health, for each clinical encounter.

(3) The CLTS MCO shall have a policy that ensures the confidential transfer of medical and dental information to another primary medical or dental service provider whenever a primary medical or dental provider leaves the CLTS MCO the member changes primary medical or dental service provider or after a member changes enrollment from one CLTS MCO and enrolls in another CLTS MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another whenever a provider leaves the SE network or whenever the member changes behavioral health provider or practitioner. The SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.

(5) The CLTS MCO/SE shall forward to HSD or it designee, specific health information from the provider's medical records. Examples of health information will include, but not be limited to, the following:

(a) the member's principal physical and behavioral health problems, as applicable;
(b) the member's current medications, dosage amounts and frequency;
(c) the member's preventive health services history; including behavioral health;
(d) EPSDT screening results (if the member is under age 21); and
(e) other information as requested.

[8.307.8.17 NMAC – N, 8-1-08]

8.307.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The CLTS MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to service providers for each medically necessary service. The CLTS MCO/SE shall submit documentation to HSD or its designee if requested, at least once per year, giving assurances that it has the capacity to serve the expected enrollment in its service area in accordance with HSD standards and in a format acceptable to HSD. The CLTS MCO/SE shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than shall be offered.

B. **Access to urgent and emergency services:** Services for emergency conditions provided by physical health providers, including emergency transportation, urgent conditions, and post-stabilization services shall be covered by the CLTS MCO only within the United States for both physical and behavioral health. The SE shall coordinate all behavioral health transportation with the member's respective CLTS MCO. An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member. Post-stabilization services means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The CLTS MCO/SE shall ensure that there is no clinically significant delay caused by the CLTS MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the

CLTS MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The CLTS MCO/SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The CLTS MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency services, regardless of whether the service provider is contracted with the CLTS MCO/SE.

(3) The CLTS MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The CLTS MCO shall follow a process that ensures a sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The CLTS MCO shall have at least one primary care provider available per 1,500 members and no more than 1,500 members assigned to a single provider unless approved by HSD or its designee.

(2) The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90 percent of urban residents shall travel no farther than 30 miles;

(b) 90 percent of rural residents shall travel no farther than 45 miles; and

(c) 90 percent of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The CLTS MCO/SE shall ensure that a sufficient number of pharmacy providers are available to members. The CLTS MCO/SE shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90 percent of urban residents shall travel no farther than 30 miles;

(2) 90 percent of rural residents shall travel no farther than 45 miles; and

(3) 90 percent of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The CLTS MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice. The SE shall ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

(1) The CLTS MCO shall report to HSD or its designee all service provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members.

(2) (CLTS MCO only) For routine, asymptomatic, member-initiated, outpatient appointments for primary medical services, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) (CLTS MCO only) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) (CLTS MCO only) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental services, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) (SE only) For non urgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) (CLTS MCO/SE) Primary medical, dental and behavioral health service outpatient appointments for urgent conditions shall be available within 24 hours.

(7) (CLTS MCO only) For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) (CLTS MCO only) For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time.

(9) (CLTS MCO only) For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

(10) (CLTS MCO only) For urgent outpatient diagnostic laboratory, diagnostic imaging and other

testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

(11) (CLTS MCO/SE) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a service provider shall be filled within 90 minutes.

(12) (CLTS MCO/SE) The timing of scheduled follow-up outpatient visits with service providers shall be consistent with the clinical need.

(13) The CLTS MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The CLTS MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.307.7.11 NMAC, *Services Included in the Salud! Benefit Package, Pharmacy Services*.

(15) The CLTS MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

(e) The CLTS MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The CLTS MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The CLTS MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the CLTS MCO lists of needed supplies monthly; and the CLTS MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The CLTS MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the CLTS MCO/SE or its subcontractor.

F. **Access to transportation services:** The CLTS MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The CLTS MCO shall coordinate behavioral health transportation services with the SE, and the SE shall coordinate transportation services with the member's respective CLTS MCO. The CLTS MCO shall have sufficient transportation service providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The CLTS MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The CLTS MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.307.8.18 NMAC – N, 8-1-08]

8.307.8.19 DELEGATION: Delegation is a process whereby a CLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The CLTS MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The CLTS MCO/SE shall document its oversight of the delegated

activity. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD and the collaborative.

A. A mutually agreed upon document between CLTS MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the CLTS MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the CLTS MCO/SE;

(4) the process by which the CLTS MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the CLTS MCO/SE if the delegated entity does not fulfill its obligations.

B. The CLTS MCO/SE shall document evidence that the CLTS MCO/SE:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively identifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the CLTS MCO/SE's expectations and HSD's standards.

[8.307.8.19 NMAC – N, 8-1-08]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 9 COORDINATION OF SERVICES

8.307.9.1 ISSUING AGENCY: Human Services Department
[8.307.9.1 NMAC]

8.307.9.2 SCOPE: This rule applies to the general public.
[8.307.9.2 NMAC]

8.307.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.9.3 NMAC]

8.307.9.4 DURATION: Permanent
[8.307.9.4 NMAC]

8.307.9.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.9.5 NMAC]

8.307.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.9.6 NMAC]

8.307.9.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.9.7 NMAC]

8.307.9.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.9.8 NMAC]

8.307.9.9 COORDINATION OF SERVICES:

A. The CLTS MCO/SE shall develop and implement policies and procedures to ensure access to service coordination for individuals with special health care needs (ISHCN), as set forth in 8.307.15.9 NMAC. Service coordination is defined as a service to assist members with special health care needs, on an as needed basis. It is person-centered, family-focused when appropriate, culturally competent, and strengths-based. Service coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and that services are provided and coordinated with all service providers, individual members and the family, if appropriate, and authorized by the member. Service coordination operates within the CLTS MCO/SE with a dedicated service coordination staff functioning independently, but is structurally linked to the other CLTS MCO/SE systems, such as quality assurance, member services and grievances. Service coordination is not “gate keeping” or “utilization management”. Clinical decisions shall be based on medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute. Services shall be coordinated between both CLTS MCO staff and behavioral health staff of the statewide entity (SE). The entity (CLTS MCO or SE) responsible for the care of the most acute condition shall be the primary lead on service coordination activities, with necessary assistance and collaboration from other entities. The CLTS MCO/SE shall conduct the following system processes for service coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific member and to serve as the single point of contact for the member; and

(4) ensure access to service coordination for all medicaid eligible ISHCN, as required by federal regulations.

B. **General service coordination requirements:**

(1) (CLTS MCO/SE) provide statewide service coordination by licensed or otherwise qualified professionals for members with multiple and complex special health care needs. Service coordinators can be licensed registered nurses (RNs), licensed practical nurses (LPNs), licensed social workers, or have a bachelor's degree from an accredited college or university in nursing, social work, counseling, special education, or a closely related field;

(2) (CLTS MCO only) empower members and their family or caregivers to make informed service coordination decisions based on their individualized service plan (ISP) priorities;

(3) (CLTS MCO only) provide support for transition and community reintegration and/or the least restrictive environment based on the member's ISP goals;

(4) (CLTS MCO only) ensure that service coordinators are meeting face-to-face at least once monthly with those individuals receiving long-term support services;

(5) (CLTS MCO/SE) develop and implement written policies and procedures approved by the state, which govern how members with multiple and/or complex special health care needs shall be identified;

(6) (CLTS MCO/SE) develop and implement written policies and procedures governing how service coordination shall be provided for members with special health care needs, as required by federal regulation. The CLTS MCO policies shall address the development of the member's ISP, based on a comprehensive assessment of the goals, capacities, and member's condition and the needs and goals of the family. Also included shall be the criteria for evaluating a member's response to services and revising the ISP when indicated. The member and/or the member's representative shall be involved in the development of the ISP, as appropriate. The member shall have the right to refuse service coordination;

(7) (CLTS MCO only) adhere to clear expectations and requirements related to ISHCN that may include, but are not limited to: direct access to specialists, as needed; relevant coordinated long-term services specialty providers; relevant emergency resource requirements; relevant rehabilitation therapy services to maintain functionality; relevant clinical practice guidelines for provision of care and services; and relevant utilization management for services;

(8) (CLTS MCO only) develop and implement written policies and procedures that ensure that health and social service delivery is coordinated across service providers, service systems, and varied levels of care to maximize the member's ISP goals and outcomes;

(9) (CLTS MCO only) develop and implement written policies and procedures that ensure that all transitions of service from institutional to community-based services are proactively coordinated with all service providers involved in the member's ISP;

(10) (CLTS MCO only) develop and implement written policies and procedures that ensure that comprehensive service delivery, across varied funding sources, such as medicare and medicaid for dually eligible members, is seamless to the member;

(11) (CLTS MCO/SE) measure and evaluate outcomes and monitor progress of members to ensure that covered services are received, and assist in resolution of identified problems that prevent duplication of covered services;

(12) (CLTS MCO only) specify how service coordination shall be supported by an internal information system;

(13) (CLTS MCO only) develop and implement written policies and procedures to establish a working relationship between service coordinators, network providers, members, and caregivers;

(14) (CLTS MCO/SE) continue to work with school-based providers to identify and coordinate with the child or adolescent's primary care provider (PCP)

C. The service coordinator shall be responsible for the following activities:

(1) (CLTS MCO/SE) communicating to the member the service coordinator's name and how to contact this person;

(2) (CLTS MCO/SE) ensuring and coordinate access to a qualified service provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) (CLTS MCO/SE) ensuring appropriate coordination between physical and behavioral health services and non-coordinated long-term services; In the case of the SE, also coordinate care among other applicable agencies and the collaborative;

(4) (CLTS MCO only) coordinating the needs and identify the status of co-managed cases with the SE behavioral health service coordinator;

(5) (CLTS MCO/SE) monitoring progress of members to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;

(6) (SE only) coordinate the provision of necessary services and actively assist members in obtaining such services when a local community case manager is not available;

(7) (SE only) develop a member's individual plan of care (care coordination plan) with involvement from the member and family/guardian (as appropriate) based on a comprehensive assessment of the goals, capabilities and the behavioral health service needs of the member and with consideration of the needs and goals of the family (if appropriate); provide for an evaluation process of the plan that measures the member's response to care and ensures revision of the plan as needed;

(8) (CLTS MCO only) ensuring the development of a member's individual plan of service, based on a comprehensive assessment of the goals, capabilities and medical condition of the member and with consideration of the needs and goals of the family; provide for an evaluation process that measures the member's response to services and ensures revision of the plan as needed;

(9) (CLTS MCO/SE) involving the member and family in the development of the plan of services, as appropriate; a member or family shall have the right to refuse service coordination or case management, that will be documented in the service coordination file; and

(10) (CLTS MCO/SE) ensuring that all necessary information is shared with key service providers with the member's written permission or documented verbal permission; this information sharing is required to ensure optimum services and communication between primary care and behavioral health care, as well as among involved behavioral health service providers and across other service providing systems.

D. Standards for Individual Service Plan Development (ISP)

(1) Treatment and service plans may be documented using a form submitted by the CLTS MCO approved by the state:

(2) Have and comply with written policies and procedures for the development of the ISP, including ensuring that: the member is involved and in control, to the extent possible and desired by the member in development of the ISP; individuals whom the member wishes to participate in the planning process are included in the planning process; the member's needs are assessed and services and goods are identified to meet those needs; the member's desired level of direct management is agreed upon; and responsibilities for implementation of the ISP are identified;

(3) Educate each member (and/or family or legal representatives, as indicated) about the person-centered planning process, the range of covered services; and, depending on the member's desired level of self-management, any additional information to assist the member during development of the ISP;

(4) Upon completion of a comprehensive assessment, according to parameters identified in the CLTS MCO contract, the CLTS MCO shall:

(a) begin the ISP development process. The member shall be the center of the planning process, in collaboration with the CLTS MCO service coordinator and other individuals of the member's planning team. The planning team shall be composed according to criteria identified in the CLTS MCO contract;

(b) convene the planning team to develop and implement the ISP in accordance with contract requirements. The CLTS MCO service coordinator will inform and educate the member (and/or his/her family, legal guardian, or representative, as indicated), about waiver services and other resources available to meet the member's needs;

(c) ensure that the member (and/or his/her family, legal guardian, or representative, as indicated), in collaboration with his/her planning team, identifies preferred outcomes for services, goals, and the supports necessary to reach the member's desired goals and outcomes. Risks associated with the outcomes, and methods to mitigate those risks shall be identified, while acknowledging and promoting the member's independence;

(d) list specific interventions in the ISP for implementing each goal including measurable objectives, services, supports, timelines, and assignments for individuals who are responsible for implementation, and methods of measuring and evaluating outcomes of the ISP. The ISP shall address all services provided to the member, including through CLTS, medicare, community resources, natural supports, and other resources;

(e) review and update the ISP annually, or more frequently, if needed, or when the member or caregiver requests; the member is at risk of significant harm; the member experiences a significant medical event or change

in condition/functioning, e.g., hospitalization, frequent falls, serious accident or illness; the member experiences a significant change in social supports or environment, e.g., caretaker becomes ill, home is damaged; or the member has been referred to adult protective services because of abuse, neglect, or exploitation.

E. For clarification purposes, activities provided through service coordination at the CLTS MCO/SE level differ from case management activities provided as part of the targeted case management programs included in the medicaid benefit package. These external case management programs shall continue to be important service components delivered as a portion of the medicaid benefit package. The case management programs are defined in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.
[8.307.9.9 NMAC]

8.307.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services shall be provided through a clinically coordinated system between the CLTS MCO and SE. The CLTS MCO and SE shall coordinate a member's services with one another, if the member has both physical and behavioral health needs. Both physical and behavioral service providers would benefit from having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. The CLTS MCO and the SE shall develop and share policies and procedures to ensure effective service coordination across systems as authorized by the member. The CLTS MCO/SE shall have defined processes for coordinating complex physical and behavioral health cases, which include participation of its medical directors. Confidentiality and HIPAA regulations apply during this coordination process.

B. **Coordination mechanisms:** The CLTS MCO/SE shall work proactively to achieve appropriate coordination between physical and behavioral health services by implementing complimentary policies and procedures for the coordination of services. The CLTS MCO/SE shall implement policies and procedures that maximize service coordination to access medicaid services external to the MCO's program, such as home and community-based waiver programs, the medicaid school-based services (MSBS) program and the children's medical services (CMS). The CLTS MCO/SE shall have procedures that ensure PCPs consistently receive communication, with the member's written consent, regarding member status and follow-up care by a specialist provider. The CLTS MCO/SE shall provide comprehensive education to its provider networks regarding HIPAA compliant protocols for sharing information between physical health, behavioral health and other providers.

C. **Referrals for behavioral health services:** The CLTS MCO shall educate and assist the PCPs regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment through the SE.

D. **Referrals for physical health services:** The SE shall educate and assist the behavioral health providers regarding proper procedures for making appropriate referral for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the written consent.

E. **Referral policies and procedures:** The CLTS MCO/SE shall offer statewide trainings to all service providers regarding its specific referral policies and procedures. The CLTS MCO/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted service providers. The CLTS MCO/SE shall develop and implement policies and procedures that encourage PCPs to refer members to the SE for behavioral health services or directly to behavioral health service providers in an appropriate and timely manner, with the member's documented permission. A member may access behavioral health services through direct contact with the SE or by going directly to a behavioral health provider. A written report of the behavioral health service containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider with the member's written consent with oversight from the SE within 7 calendar days after screen and evaluation. The CLTS MCO shall ensure that its policies and procedures for service coordination ensure that referrals to other specialists, non-network providers, and all publicly supported providers for medically necessary and home and community-based covered services are available to members, if such services are not reasonably available in the CLTS MCO network. The CLTS MCO policy for non-network providers shall require the CLTS MCO to coordinate with the non-network provider with regard to payment unless otherwise agreed to by the CLTS MCO and HSD or its designee.

F. **Indicators for PCP referral to behavioral health services:** The following are common indicators for a referral to the SE for behavioral health services or for a referral directly to a behavioral health provider by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement;

(4) trauma victims including possible abused or neglected members;

(5) serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

(6) request by member, parent or legal guardian of a minor for behavioral health services;

(7) clinical status that suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral, psychiatric or substance abuse factors influencing a medical condition;

(11) victims or perpetrators of abuse and neglect;

(12) non-medical management of substance abuse;

(13) follow-up to medical detoxification;

(14) an initial PCP contact or routine physical examination indicates a substance abuse or mental health problem;

(15) a prenatal visit indicates a substance abuse or mental health problem;

(16) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(17) a pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(18) the persistence of serious functional impairment.

G. **Referrals for physical health or behavioral health consultation and treatment:** The CLTS MCO shall educate and assist physical health providers to make appropriate referrals for behavioral health consultation and treatment. The SE shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment to the medicaid member's PCP or CLTS MCO as authorized by the member.

H. **Independent access:** The CLTS MCO/SE shall develop and implement policies and procedures that allow member's access to behavioral health services through the SE directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan:** The behavioral health provider designated as the "clinical home" shall take responsibility for developing and implementing the member's behavioral health treatment plan in coordination with the member, parent or legal guardian and other service providers, when clinically indicated. With the member's documented permission, multiple behavioral health providers shall coordinate their treatment plans and progress information to provide optimum service for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health services from multiple service providers.

J. **On-going reporting:**

(1) The CLTS MCO shall require that a PCP must keep the member's behavioral health provider informed, with the member's written consent, of the following:

(a) drug therapy;

(b) laboratory and radiology results;

(c) medical consultations; and

(d) sentinel events such as hospitalization and emergencies.

(2) The SE shall require that a behavioral health provider must keep the member's PCP informed, with the member's written consent, of the following;

(a) drug therapy;

(b) laboratory and radiology results'

(c) sentinel events such as hospitalization, emergencies and incarceration;

(d) discharge from a psychiatric hospital, residential treatment services, treatment foster care placement, or from other behavioral health services; and

(e) all transitions in level of care

K. **Psychiatric consultation:** The PCP and all behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from an SE contracted psychiatrist or other behavioral health specialist with prescribing authority, when clinically appropriate.
[8.307.9.10 NMAC]

8.307.9.11 COORDINATION WITH WAIVER PROGRAMS: The CLTS MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex service coordination. The CLTS MCO/SE shall coordinate services with the member's waiver case manager to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD or its designee shall monitor utilization of services by waiver recipients to ensure that the CLTS MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.
[8.307.9.11 NMAC]

8.307.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT (CYFD) AND AGING AND LONG TERM SERVICES DEPARTMENT (ALTSD): The CLTS MCO/SE shall have policies and procedures governing coordination of services with the CYFD protective services division (PSD) and juvenile justice division (JJD). If the member is receiving case management services through CYFD, the primary responsibility for the case management function remains with CYFD, and the CLTS MCO/SE shall assist with service coordination. If child protective services (CPS) or juvenile justice division (JJD) has an open case on a member, the CYFD social worker assigned to the case shall be involved in the assessment and treatment plan, including decisions regarding the provision of services for the member. The CLTS MCO/SE shall have policies and procedures governing coordination of services with ALTSD's adult protective services. The CLTS MCO/SE shall ensure that any APS worker actively involved in an individual's life is included in service coordination. The CLTS MCO/SE shall assist CYFD and ALTSD staff in identifying access to all medically necessary services identified in the service coordination plan. The CLTS MCO/SE shall designate a single contact point within the CLTS MCO/SE for service coordination purposes.

A. **Children's Code compliance:** The CLTS MCO/SE policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The CLTS MCO/SE's policies and procedures shall comply with New Mexico Statutes, Chapter 27, Section 7 (27-7-14 through 27-7-31), the "Adult Protective Services Act."
[8.307.9.12 NMAC]

8.307.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The CLTS MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from coordinated long-term services, as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for the case management function remains with the school, and the CLTS MCO/SE shall assist with service coordination. Coordination between the schools and the CLTS MCO/SE shall ensure that members receive medically necessary services that complement the IEP or IFSP services and promote the highest level of function for the child. The CLTS MCO/SE shall be responsible for implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, residential treatment services or treatment foster care placement.
[8.307.9.13 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 10 ENCOUNTERS

8.307.10.1 ISSUING AGENCY: Human Services Department
[8.307.10.1 NMAC]

8.307.10.2 SCOPE: This rule applies to the general public.
[8.307.10.2 NMAC]

8.307.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute See NMSA 1978 Section 27-2-12 et. seq.
[8.307.10.3 NMAC]

8.307.10.4 DURATION: Permanent
[8.307.10.4 NMAC]

8.307.10.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.10.5 NMAC]

8.307.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.10.6 NMAC]

8.307.10.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.10.7 NMAC]

8.307.10.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.10.8 NMAC]

8.307.10.9 ENCOUNTERS: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall submit encounter data to the human services department (HSD) under requirements established by HSD or its designee. The centers for medicare and medicaid services (CMS) require that encounter data be used for rate-setting purposes and for reporting cost neutrality for services rendered under the section 1915(c) waiver. HSD maintains oversight responsibility for evaluating and monitoring the volume, timeliness and quality of encounter data submitted by the CLTS MCO/SE. If a CLTS MCO/SE contracts with a third party to process and submit encounter data, the CLTS MCO/SE remains responsible for the quality, accuracy and timeliness of the encounter data submitted to HSD. HSD or its designee shall communicate directly with the CLTS MCO/SE, not with the third party contractor, regarding requirements, deficiencies, quality, accuracy and timeliness of encounter data. CLTS MCO/SE encounter data shall be used to determine compliance with performance measures and other contractual requirements, as appropriate.
[8.307.10.9 NMAC]

8.307.10.10 ENCOUNTER SUBMISSION MEDIA: Encounter data shall be submitted to HSD or its designee on electronic media, as designated and directed by HSD.
[8.307.10.10 NMAC]

8.307.10.11 ENCOUNTER SUBMISSION TIMEFRAMES: The CLTS MCO/SE shall submit encounter data to HSD within 120 days of the service delivery date or discharge. HSD or its designee shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.307.10.11 NMAC]

8.307.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are a combination of those elements required by Health Insurance Portability and Accountability Act of 1996 (HIPAA) -compliant transaction formats, which comprise a minimum core data set for states and the CLTS MCO/SE, and those required by CMS, HSD or the collaborative for use in the coordinated long-term services program. Encounter data elements are specified in the medicaid systems manual. HSD or its designee may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.307.10.12 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 11 REIMBURSEMENT FOR COORDINATED LONG-TERM SERVICES

8.307.11.1 ISSUING AGENCY: Human Services Department
[8.307.11.1 NMAC]

8.307.11.2 SCOPE: This rule applies to the general public.
[8.307.11.2 NMAC]

8.307.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq.
[8.307.11.3 NMAC]

8.307.11.4 DURATION: Permanent
[8.307.11.4 NMAC]

8.307.11.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.11.5 NMAC]

8.307.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.11.6 NMAC]

8.307.11.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.11.7 NMAC]

8.307.11.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.11.8 NMAC]

8.307.11.9 REIMBURSEMENT FOR COORDINATED LONG-TERM SERVICES:

A. **Payment for services:** The human services department (HSD) shall make actuarially sound payments under capitated risk contracts to the designated coordinated long-term services managed care organizations (CLTS MCOs) and single statewide entity (SE). Rates, whether set by HSD or negotiated between HSD and the CLTS MCO/SE, are considered confidential. Rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. The CLTS MCO/SE shall be responsible for the provision of services to members during the month of capitation. Medicaid members shall not be liable for debts incurred by a CLTS MCO/SE under the CLTS MCO's/SE's contract for providing health services to medicaid members. This shall include, but not be limited to:

(1) the CLTS MCO's/SE's debts in the event of its insolvency;

(2) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the CLTS MCO/SE, e.g. value added services;

(3) when the CLTS MCO/SE does not pay the service provider that furnishes the services under contractual, referral, or other arrangement;

(4) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the CLTS MCO/SE provided the service directly; and

(5) if a CLTS MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the CLTS MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefit services supplied to the member.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the CLTS MCO/SE for the provision of the coordinated long-term services benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The CLTS MCO/SE shall accept the capitation rate paid each

month by HSD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. HSD or its designee will calculate or verify the CLTS MCO's/SE's income at the end of the state fiscal year to determine if expenditures were made on the services required under the contract utilizing reported information and the department of insurance reports. Administrative costs, to be no higher than the allowable percent, including all CLTS MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The CLTS MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the CLTS MCO/SE not meet the required administrative or direct services costs within the terms of the contract, sanctions or financial penalties may be imposed.

C. **Payment timeframes:** Clean claims as defined in Subsection L of 8.307.1.7 NMAC, *Definitions*, shall be paid by the CLTS MCO/SE to contracted and noncontracted service providers according to the following timeframe: 90% within 30 days of the date of receipt, and 99% within 90 days of the date of receipt, as required by federal guidelines in 42 CFR §447.45. The date of receipt is the date that the CLTS MCO/SE first receives the claim, either manually or electronically. The CLTS MCO/SE is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the CLTS MCO/SE and its service providers, by mutual agreement, establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the CLTS MCO/SE. The CLTS MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by non-contracted service providers, at no more than the medicaid fee-for-service (FFS) rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) A CLTS MCO/SE shall pay contracted and noncontracted service providers interest on the CLTS MCO's/SE's liability at the rate of 1.5% per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating service provider and not paid within 30 days of the date of receipt of an electronic claim, and 45 days of receipt of a manual claim. Interest shall accrue from the 31st day for electronic claims and from the 46th day for manual claims. The CLTS MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD or its designee.

(2) No contract between the CLTS MCO/SE and a participating service provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the CLTS MCO/SE is unable to determine liability for, or refuses to pay, a claim from a participating service provider within the times specified above, the CLTS MCO/SE shall make a good-faith effort to notify the participating service provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating the specific reasons why it is not liable for the claim, or to request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the CLTS MCO/SE for the provision of the coordinated long-term services benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

E. **Payment on a risk basis:** The CLTS MCO/SE is at risk of incurring losses if its costs of providing the coordinated long-term services benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the CLTS MCO/SE to reflect the actual cost of services furnished by the CLTS MCO/SE.

F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the contract and annually thereafter. HSD may adjust the capitation rates based on factors such as the following: changes in the scope of work; federal requirement for modification of a waiver; new or amended federal or state laws or regulations are implemented; inflation; or if significant changes in the demographic characteristics of the member population occur.

G. **Solvency requirements and risk protections:** A CLTS MCO/SE that contracts with HSD to provide coordinated long-term health services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the CLTS MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the CLTS MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD or its designee, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** A CLTS MCO participating in the coordinated long-term services program shall purchase reinsurance at a minimum of one million dollars ($1,000,000.00) in reinsurance protection against financial loss due to outlier (catastrophic) cases. The CLTS MCO shall provide documentation to HSD or its designee that reinsurance is in effect through the term of the contract and that the amount of reinsurance is sufficient to cover

probable outlier cases or overall member utilization at an amount greater than expected. Pursuant to 42 CFR 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, and other risk-sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The CLTS MCO/SE shall be responsible for identifying a member's third party coverage and coordinating benefits with third parties as required by federal law. The CLTS MCO/SE shall inform HSD or its designee when a member has other health care insurance coverage. The CLTS MCO shall have the sole right of subrogation, for 12 months from when it incurred the cost on behalf of the member, to initiate recovery or to attempt to recover any third-party resources available to medicaid members; and shall make records pertaining to third party collections for members available to HSD or its designee for audit and review. If the CLTS MCO has not initiated recovery or attempted to recover any third-party resources available to medicaid members within 12 months, HSD will pursue the member's third party resources. The CLTS MCO/SE shall provide to HSD or its designee for audit and review all records pertaining to TPL collections for its members.

(3) **Fidelity bond requirement:** The CLTS MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The CLTS MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The CLTS MCO/SE shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of CLTS MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The CLTS MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of CLTS MCO/SE members, or the failure of the CLTS MCO/SE to maintain a cash reserve equal to three percent, and shall notify the CLTS MCO/SE of the cash reserve requirement. Each CLTS MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment of services to the CLTS MCO's/SE's members in the event that the CLTS MCO/SE becomes insolvent. Money in the reserve account remains the property of the CLTS MCO/SE, and any interest earned (even if retained in the account) shall be the property of the CLTS MCO/SE.

H. **Inspection and audit for solvency requirements:** The CLTS MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The CLTS MCO/SE shall provide to HSD or its designee all financial records required by HSD. HSD, or its designee, may inspect and audit the CLTS MCO's/SE's financial records at least annually or at HSD discretion.

I. **Special payment requirements:** This section lists special payment requirements by service provider type:

(1) **Reimbursement for federally qualified health centers (FQHCs):** Under federal law, FQHCs shall be reimbursed at 100% of reasonable cost under a medicaid FFS or managed care program. The FQHC may waive its right to 100% of reasonable cost and elect to receive a rate negotiated with the CLTS MCO/SE. HSD shall provide a discounted wrap-around payment to FQHCs that have waived a right to 100% reimbursement of reasonable cost from the CLTS MCO/SE.

(2) **Reimbursement for providers furnishing services to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to a CLTS MCO/SE member who is Native American, the CLTS MCO/SE shall reimburse the provider at the rate established by the office of management and budget (OMB) for specified services at IHS facilities, except when otherwise specified by HSD.

(3) **Reimbursement for family planning services:** The CLTS MCO shall reimburse out-of-network family planning providers for services provided to its members at a rate at least equal to the medicaid FFS rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in coordinated long-term services has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not contracted with the CLTS MCO, the CLTS MCO shall reimburse the out-of-network provider for services directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** If a medicaid member is hospitalized at the time of disenrollment, the organization that was originally responsible for the hospital impatient placement, shall remain financially responsible for payment of all covered inpatient facility and professional services from the date of admission to the date of discharge, or upon transfer to a lower level of care. Upon discharge, the member will then become the financial responsibility of the organization receiving capitation payments.

(6) **Sanctions for noncompliance:** HSD may impose financial penalties or sanctions against a CLTS MCO/SE that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid coordinated long-term services contract or federal medicaid law.

J. **Recoupment payments:** HSD shall recoup payments for CLTS MCO members who are incorrectly enrolled with more than one CLTS MCO; payments made for CLTS MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the CLTS MCO/SE for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the CLTS MCO/SE or HSD shall be recouped upon identification. In the event of an error that causes payment(s) to the CLTS MCO/SE to be issued by HSD, HSD shall recoup the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the 30th day following the notice. Any process that automates recoupment procedures shall be discussed in advance by HSD and the CLTS MCO/SE, and documented in writing prior to implementation of the new automated recoupment process. The CLTS MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at 9% per annum on any capitation payment due to the CLTS MCO/SE that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate an alternate payment methodology for specified program services or responsibilities.

[8.307.11.9 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 12 MEMBER GRIEVANCE SYSTEM

8.307.12.1 ISSUING AGENCY: Human Services Department
[8.307.12.1 NMAC]

8.307.12.2 SCOPE: This rule applies to the general public.
[8.307.12.2 NMAC]

8.307.12.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.12.3 NMAC]

8.307.12.4 DURATION: Permanent
[8.307.12.4 NMAC]

8.307.12.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.12.5 NMAC]

8.307.12.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.12.6 NMAC]

8.307.12.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.12.7 NMAC]

8.307.12.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.12.8 NMAC]

8.307.12.9 GENERAL REQUIREMENTS FOR GRIEVANCES AND APPEALS:

A. The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall have a grievance system in place for members that includes a grievance process related to dissatisfaction and an appeals process related to a CLTS MCO/SE action, including the opportunity to request a human services department (HSD) fair hearing.

B. The CLTS MCO/SE shall implement written policies and procedures describing how the member may submit a request for a grievance or an appeal with the CLTS MCO/SE, or submit a request for a fair hearing with HSD. The policy shall include a description of how the CLTS MCO/SE resolves the grievance or appeal.

C. The CLTS MCO/SE shall provide to all service providers in the CLTS MCO's/SE's network a written description of its grievance and appeal process and how providers can submit a grievance or appeal.

D. The CLTS MCO/SE shall make 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.

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

F. The CLTS MCO/SE shall ensure that the individuals who make decisions on grievances or appeals are not involved in any previous level of review or decision-making. The CLTS MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

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

G. Upon enrollment, the CLTS MCO/SE shall provide members, at no cost, with a member information sheet or handbook that provides information on how they or their representative(s) can file a grievance 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 fair hearings bureau, upon notification of a CLTS MCO/SE action, or concurrent with, subsequent to or in lieu of an appeal of the CLTS MCO/SE action. The information shall meet the standards specified in Paragraph (15) of Subsection C of 8.307.8.15 NMAC.

H. The CLTS MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or service provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal. [8.307.12.9 NMAC]

8.307.12.10 GRIEVANCE: A grievance is an expression of dissatisfaction about any matter or aspect of the CLTS MCO/SE or its operation, other than a CLTS MCO/SE action.

A. A member may file a grievance either orally or in writing with the CLTS MCO/SE within 90 calendar days of the date of the event causing the dissatisfaction. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the CLTS MCO/SE, or a service 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 working days of receipt of the grievance, the CLTS MCO/SE 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 CLTS MCO/SE resolution process for grievances shall be completed within 30 calendar days of the date the grievance is received by the CLTS MCO/SE and shall include a resolution letter to the grievant.

D. The CLTS MCO/SE may request an extension from HSD or its designee of up to 14 calendar days if the member requests the extension, or the CLTS MCO/SE 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 CLTS MCO/SE shall give the member written notice of the reason for the extension within two working days of the decision to extend the timeframe.

E. Upon resolution of the grievance, the CLTS MCO/SE shall mail a resolution letter to the member. The resolution letter shall 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.

[8.307.12.10 NMAC]

8.307.12.11 APPEALS: An appeal is a request for review by the CLTS MCO/SE of a CLTS MCO/SE action.

A. An 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 CLTS MCO/SE to provide services in a timely manner, as defined by HSD or its designee; or
(5) the failure of the CLTS MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. **Notice of CLTS MCO/SE action:** The CLTS MCO/SE shall mail a notice of action to the member or service provider within 10 days of the date of the action for previously authorized services as permitted under 42 CFR 431.213 and 431.214, and within 14 days of the date of the action for newly requested services. Denials of claims that may result in member financial liability require immediate notification. The notice shall contain, but not be limited to, the following:

(1) the action the CLTS MCO/SE has taken or intends to take;
(2) the reasons for the action;
(3) the member's or the service provider's right, as applicable, to file an appeal of the CLTS MCO/SE action through the CLTS MCO/SE;
(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;

(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 a CLTS MCO/SE action within 90 calendar days of receiving the CLTS MCO's/SE's notice of action. The legal guardian of the member for a minor or an incapacitated adult, a representative of the member as designated in writing to the CLTS MCO/SE, or a service 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 CLTS MCO/SE shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

D. The CLTS MCO/SE has 30 calendar days from the date the initial oral or written appeal is received by the CLTS MCO/SE to resolve the appeal. The CLTS MCO/SE 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 CLTS MCO/SE shall have a process in place that ensures that an oral or written 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 shall be followed by a written appeal that is signed by the member within 10 calendar days. The CLTS MCO/SE shall use its best efforts to assist members as needed with the written appeal and may continue to process the appeal.

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

G. The CLTS MCO/SE may extend the 30-day timeframe by 14 calendar days if the member requests the extension, or the CLTS MCO/SE 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 CLTS MCO/SE shall 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 CLTS MCO/SE shall provide the member or the member's representative a reasonable opportunity to present evidence of the facts or law, in person as well as in writing.

I. The CLTS MCO/SE shall provide the member or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records (subject to HIPAA requirements), and any other documents and records considered during the appeals process. The CLTS MCO/SE 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 CLTS MCO/SE shall provide written notice within the 30-calendar-day timeframe for resolutions to the member or the service provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution shall include, but not be limited to, the following information:

(a) the results 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 shall 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 continuing benefits if the hearing decision upholds the CLTS MCO's/SE's action.

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

(1) The CLTS MCO/SE shall continue the member's benefits if all of the following are met:

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

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

(e) the member requests extension of the benefits.

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

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, 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 CLTS MCO's/SE's action is upheld, the CLTS MCO/SE 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 431.230(b).

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

(5) If the CLTS MCO/SE or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the CLTS MCO/SE shall pay for these services.
[8.307.12.11 NMAC]

8.307.12.12 EXPEDITED RESOLUTION OF APPEALS: An expedited resolution of an appeal is an expedited review by the CLTS MCO/SE of a CLTS MCO/SE action.

A. The CLTS MCO/SE shall establish and maintain an expedited review process for appeals when the CLTS MCO/SE determines that allowing 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 service provider's support of the member's request;

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

(4) the CLTS MCO's/SE's independent determination.

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

C. The CLTS MCO/SE shall resolve the appeal within three working days of receipt of the request for an expedited appeal, if the request meets the definition of expedited in Subsection A of 8.307.12.13 NMAC. In addition to written resolution notice, the CLTS MCO/SE shall also make reasonable efforts to provide and document oral notice.

D. The CLTS MCO/SE may extend the timeframe by up to 14 calendar days if the member requests the extension, or the CLTS MCO/SE 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 CLTS MCO/SE shall give the member written notice of the reason for the delay.

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

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

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

H. If the CLTS MCO/SE 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 30-day period begins on the date the CLTS MCO/SE received the original request for appeal; and

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

I. The CLTS MCO/SE shall document in writing all oral requests for expedited resolution and shall maintain the documentation in the case file.
[8.307.12.12 NMAC]

8.307.12.13 SPECIAL RULE FOR CERTAIN EXPEDITED SERVICE AUTHORIZATION DECISIONS: In the case of expedited service authorization decisions that deny or limit services, the CLTS

MCO/SE shall, within 72 hours of receipt of the request for service, automatically file an appeal on behalf of the member, use its best effort, to give the member oral notice of the decision on the automatic appeal and to resolve the appeal.
[8.307.12.13 NMAC]

8.307.12.14 OTHER RELATED PROCESSES:

A. **Information about grievance system to providers and subcontractors**: The CLTS MCO/SE shall provide information specified in 42 CFR 438.10(g)(1) about the grievance system to all service providers and subcontractors at the time they enter into a contract.

B. **Grievance and/or appeal files:**

(1) All grievance and/or appeal files shall be maintained in a secure and designated area and be accessible to HSD or its designee , upon request, for review. Grievance and/or appeal files shall be retained for 10 years following the final decision by the CLTS MCO/SE, HSD, an administrative law judge, judicial appeal, or closure of a file, whichever occurs later.

(2) The CLTS MCO/SE shall have procedures for assuring that files contain sufficient information to identify the grievance and/or appeal, the date it was received, the nature of the grievance and/or appeal, notice to the member of receipt of the grievance and/or appeal, all correspondence between the CLTS MCO/SE and the member, the date the grievance and/or appeal is resolved, the resolution, the notices of final decision to the member, and all other pertinent information.

(3) Documentation regarding the grievance shall be made available to the member, if requested.
[8.307.12.14 NMAC]

8.307.12.15 PROVIDER GRIEVANCE AND APPEAL PROCESS: The CLTS MCO/SE shall establish and maintain written policies and procedures for the filing of provider grievances and appeals. A service provider shall have the right to file a grievance or an appeal with the CLTS MCO/SE. Provider grievances or appeals shall be resolved within 30 calendar days. If the grievance or appeal is not resolved within 30 days, the CLTS MCO/SE shall request a 14 day extension from the service provider. If the service provider requests the extension, the extension shall be approved by the CLTS MCO/SE. A service provider may not file a grievance or an appeal on behalf of a member without written designation by the member as the member's representative. A service provider shall have the right to file an appeal with the CLTS MCO/SE regarding provider payment or contractual issues. See 8.307.12.13 NMAC for special rules for certain expedited service authorizations.
[8.307.12.15 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 13 FRAUD AND ABUSE

8.307.13.1 ISSUING AGENCY: Human Services Department
[8.307.13.1 NMAC]

8.307.13.2 SCOPE: This rule applies to the general public.
[8.307.13.2 NMAC]

8.307.13.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq.
[8.307.13.3 NMAC]

8.307.13.4 DURATION: Permanent
[8.307.13.4 NMAC]

8.307.13.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.13.5 NMAC]

8.307.13.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.13.6 NMAC]

8.307.13.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.13.7 NMAC]

8.307.13.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.13.8 NMAC]

8.307.13.9 FRAUD AND ABUSE: The human services department (HSD) is committed to the development and implementation of an aggressive prevention, detection, monitoring and investigation program to reduce provider/member fraud and abuse, and member abuse and neglect. If fraud or abuse is discovered, HSD shall seek applicable administrative, civil and criminal penalties, sanctions and other forms of relief. This applies to all individuals participating in or contracting with HSD for provision or receipt of medicaid services. The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall comply with provisions of state and federal fraud and abuse laws and regulations.
[8.307.13.9 NMAC]

8.307.13.10 COORDINATED LONG-TERM SERVICES MANAGED CARE ORGANIZATION REQUIREMENTS: The CLTS MCO/SE shall have in place internal controls, policies and procedures for the prevention, detection, investigation, and reporting of potential fraud and abuse activities concerning service providers and members. The CLTS MCO's/SE's specific internal controls, 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 plan shall be approved by HSD or its designee. The CLTS MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by consumers or service providers to HSD or its designee. The CLTS MCO/SE 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. have specific controls in place for preventing and detecting potential cases of fraud and abuse, such as claims edits, post processing review of claims, service provider profiling/exception reporting and credentialing, prior authorizations, and utilization/quality management monitoring;

C. have a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid coordinated long-term services;

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

E. report to HSD or its designee the names of all service providers identified with aberrant utilization, according to service provider profiles, regardless of the cause of the aberrancy;

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

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

(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 CLTS MCO's/SE'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 Paragraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's or 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 CLTS MCO's/SE'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 CLTS MCO's/SE's contract.

[8.307.13.10 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 14 REPORTING REQUIRMENTS

8.307.14.1 ISSUING AGENCY: Human Services Department
[8.307.14.1 NMAC]

8.307.14.2 SCOPE: This rule applies to the general public.
[8.307.14.2 NMAC]

8.307.14.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.14.3 NMAC]

8.307.14.4 DURATION: Permanent
[8.307.14.4 NMAC]

8.307.14.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.14.5 NMAC]

8.307.14.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.14.6 NMAC]

8.307.14.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.14.7 NMAC]

8.307.14.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.14.8 NMAC]

8.307.14.9 REPORTING REQUIREMENTS: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall provide to the human services department (HSD) managerial, financial, delegation, suspicious activity, utilization, and quality reports. The content, format and schedule for submission shall be determined by HSD or its designee in writing. HSD or its designee may require the CLTS MCO/SE to prepare and submit ad hoc reports.
[8.307.14.9 NMAC]

8.307.14.10 REPORTING STANDARDS:

A. Reports submitted by the CLTS MCO/SE to HSD shall meet certain standards:

(1) The CLTS MCO/SE shall verify the accuracy of data and other information on reports submitted.

(2) Reports or other required data shall be received on or before scheduled due dates.

(3) Reports or other required data shall conform to HSD's defined standards as specified in writing.

(4) All required information shall be fully disclosed in a manner that is responsive and with no material omission.

(5) The CLTS MCO/SE shall analyze all required reports internally before submitting them to HSD or its designee. The CLTS MCO/SE shall analyze reports for any early patterns of change, identified trends, or outliers (catastrophic cases), and shall submit this analysis with the required reports. The CLTS MCO/SE shall send a written narrative for specified reports with the report documenting the CLTS MCO's/SE's interpretation of early patterns of change, identified trends, or outliers.

B. **Consequences of violation of reporting standards:** The submission of late, inaccurate or otherwise incomplete reports shall be considered failure to report. Sanctions may be imposed by HSD, or its designee, on the CLTS MCO/SE for failure to submit accurate and timely reports.

C. **Changes in requirements:** HSD's requirements regarding reports, report content and frequency of submission may change during the term of the contract. The CLTS MCO/SE shall comply with changes specified by HSD or its designee.
[8.307.14.10 NMAC]

8.307.14.11 MANAGERIAL REPORTS: Managerial reports demonstrate compliance with the operational requirements of the contract. These reports shall include, but not be limited to, information on such topics as:

A. CLTS MCO/SE: composition of current provider networks and capacity to take new members;
B. CLTS MCO/SE: changes in the composition and capacity of provider networks;
C. CLTS MCO: primary care provider (PCP)-to-member ratios;
D. CLTS MCO/SE: identification of third-party liability;
E. CLTS MCO/SE: grievance system activity;
F. CLTS MCO/SE: fraud and abuse detection activities;
G. CLTS MCO/SE: delegation oversight activities; and
H. CLTS MCO/SE: member satisfaction.

[8.307.14.11 NMAC]

8.307.14.12 FINANCIAL REPORTS: Financial reports demonstrate the CLTS MCO's/SE's ability to meet its commitments under the terms of the contract. The format, content and frequency for submitting financial reports shall be determined by HSD or its designee. The CLTS MCO/SE shall meet the following general requirements:

A. The CLTS MCO shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of coordinated long-term services revenues and expenses. The SE shall submit annual audited financial statements, including, but not limited to, its income statement, a statement of changes in financial condition or cash flow and a balance sheet, and shall include an audited schedule of coordinated long-term services behavioral health revenues and expenses. The result of the CLTS MCO's/SE's annual audit and related management letters shall be submitted no later than 150 days following the close of the CLTS MCO's/SE's fiscal year. The audit shall be performed by an independent certified public accountant. The CLTS MCO/SE shall submit for examination any financial reports requested by HSD or its designee.

B. The CLTS MCO/SE and their subcontractors shall maintain their accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted systems of accounting. The accounting system shall clearly document all financial transactions between the CLTS MCO/SE and their subcontractors and the CLTS MCO/SE and HSD. These transactions shall include, but not be limited to, claim payments, refunds and adjustments of payments.

C. The CLTS MCO/SE and their subcontractors shall make available to HSD, and other authorized state or federal agencies, all financial records required to examine compliance by the CLTS MCO/SE, in so far as those records are related to CLTS MCO/SE performance under the contract. The CLTS MCO/SE and their subcontractors shall provide HSD or its designee access to their facilities for the purpose of examining, reviewing and inspecting the CLTS MCO's/SE's records.

D. The CLTS MCO/SE and their subcontractors shall retain all records and reports relating to agreements with HSD for a minimum of 10 years after the date of final payment. In cases involving incomplete audits and unresolved audit findings, administrative sanctions or litigation, the minimum 10 year retention period shall begin on the date such actions are resolved.

E. The CLTS MCO/SE is mandated to notify HSD or its designee immediately when any change in ownership is anticipated. The CLTS MCO/SE shall submit a detailed work plan to the department of insurance during the transition period no later than the date of the sale. The work plan shall identify areas of the contract that may be impacted by the change in ownership, including management and staff. The CLTS MCO/SE shall submit records involving any business restructuring when changes in ownership interest in the CLTS MCO/SE of 5% or more have occurred. These records shall include, but not be limited to, an updated list of names and addresses of all persons or entities having ownership interest in the CLTS MCO/SE of 5% or more. These records shall be provided no later than 60 days following the change in ownership.
[8.307.14.12 NMAC]

8.307.14.13 UTILIZATION AND QUALITY MANAGEMENT REPORTING: Utilization and quality management reports shall demonstrate compliance with HSD's service delivery and quality standards. These reports shall include, but not be limited to:

A. regular reporting that describes critical incidents as specified by HSD or its designee. For this purpose, critical incidents contribute to a trend that has a negative impact on areas such as quality of services, access to services or service delivery as defined by HSD or its designee;

B. regular reporting of encounter data as specified by HSD or its designee;

C. regular reporting of utilization management activity; and

D. other required reports as determined by HSD or its designee, including, but not limited to, performance and tracking measures.

[8.307.14.13 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 15 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

8.307.15.1 ISSUING AGENCY: Human Services Department
[8.307.15.1 NMAC]

8.307.15.2 SCOPE: This rule applies to the general public.
[8.307.15.2 NMAC]

8.307.15.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.15.3 NMAC]

8.307.15.4 DURATION: Permanent
[8.307.15.4 NMAC]

8.307.15.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.15.5 NMAC]

8.307.15.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.15.6 NMAC]

8.307.15.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.15.7 NMAC]

8.307.15.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.15.8 NMAC]

8.307.15.9 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS (ISHCN):

A. ISHCN require a broad range of primary, specialized medical, behavioral health and related services. ISHCN 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. ISHCN 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 CLTS MCO/SE 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 ISHCN:** The CLTS MCO/SE shall have written policies and procedures in place, with the human services department's (HSD's) or its designee's approval, that govern how members with multiple and complex physical and behavioral health service needs shall be identified. The CLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target members for the purpose of applying stratification criteria to identify ISHCN. The CLTS MCO/SE shall employ reasonable efforts to identify ISHCN based at least on the following criteria:

(1) individuals eligible for supplemental security income (SSI);
(2) individuals enrolled in the home-based waiver programs;
(3) children receiving foster care or adoption assistance support;
(4) individuals identified by service utilization, clinical assessment, or diagnosis; and
(5) referral by family or a public or community program.

[8.307.15.9 NMAC]

8.307.15.10 COORDINATED LONG-TERM SERVICES ENROLLMENT FOR ISHCN:

A. **Switch enrollment:** The CLTS MCO shall have policies and procedures to facilitate a smooth transition for members who switch enrollment to another CLTS MCO. See Subsection F of 8.307.5.9 NMAC, *Member Switch Enrollment*. Members, including ISHCN, may request to break a lock-in and be switched to membership in another CLTS MCO, based on cause. The member and/or the member's family or legal guardian shall contact HSD or its designee to request that the member be switched to another CLTS MCO.

B. **ISHCN information and education:**

(1) The CLTS MCO/SE shall develop and distribute information and materials specific to the needs of ISHCN to ISHCN members, caregivers, and parents or legal guardians, as appropriate. This includes information such as items and services that are provided or not provided by the coordinated long-term services program, how to arrange transportation, and which services require a referral from the member's primary care provider (PCP). The individual, family, caregiver, or legal guardian shall be informed on how to present an individual for services in an emergency room that is unfamiliar with the individual's special health service needs, and about the availability of service coordination. See 8.307.9 NMAC, *Coordination of Services*. This information may be included in either a special member handbook or in an ISHCN insert to the CLTS MCO/SE member handbook.

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

(3) The CLTS MCO/SE shall provide ISHCN or caregivers a list of key CLTS MCO/SE resource people and their telephone numbers. The CLTS MCO/SE shall designate a single point of contact that an ISHCN member, family member, caregiver, or service provider may call for information.

[8.307.15.10 NMAC]

8.307.15.11 CHOICE OF SPECIALIST AS PCP: The CLTS MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an ISHCN to choose a specialist as a PCP. The specialist provider must agree to be the PCP.

[8.307.15.11 NMAC]

8.307.15.12 SPECIALTY PROVIDERS FOR ISHCN: The CLTS MCO/SE shall have policies and procedures in place to allow direct access to necessary specialty services, consistent with coordinated long-term services access appointment standards for clinical urgency, including behavioral health access standards. See 8.307.8.18 NMAC, S*tandards for Access*.

[8.307.15.12 NMAC]

8.307.15.13 TRANSPORTATION FOR ISHCN: The CLTS MCO shall:

A. have written policies and procedures in place to ensure that the appropriate level of transportation is arranged, based on the individual's clinical condition;

B. have past member service data available at the time services are requested to expedite appropriate arrangement;

C. ensure that CPR-certified drivers transport ISHCN if clinically indicated;

D. have written policies and procedures to ensure that the transportation mode is clinically appropriate, including access to non-emergency ground carriers;

E. develop and implement written policies and procedures to ensure that individuals can access and receive authorization for needed transportation services under certain unusual circumstances without the usual advance notification;

F. develop and implement a written policy regarding the transportation of minors to ensure the minor's safety;

G. distribute clear and detailed written information to ISHCN and, if needed, to their caregivers, on how to obtain transportation services, and also make this information available to network providers; and

H. coordinate transportation needs with the SE. The SE shall also coordinate the transportation needs of its population with the member's respective CLTS MCO.

[8.307.15.13 NMAC]

8.307.15.14 CARE COORDINATION FOR ISHCN: The CLTS MCO/SE shall develop policies and procedures to provide service coordination for ISHCN. Refer to Section 8.307.9.9 NMAC, *Coordination of*

Services, for definition.

A. The CLTS MCO/SE shall have an internal operational process, in accordance with policies and procedures, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor shall provide HSD or its designee with the applicable policies and procedures describing the targeting and stratification process.

B. The CLTS MCO/SE shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for service coordination. If the member has both physical and behavioral health special needs, the CLTS MCO and SE shall coordinate services in a timely and collaborative manner.

C. The CLTS MCO/SE shall have written policies and procedures for educating ISHCN needs and, in the case of children with special health care needs, parent and legal guardians, that service coordination is available and when it may be appropriate to their needs.

[8.307.15.14 NMAC]

8.307.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The CLTS MCO/SE shall develop and implement policies and procedures for:

A. educating ISHCN members, ISHCN family members and/or caregivers on how to access emergency room services and what clinical history to provide when emergency services or inpatient admission are needed, including behavioral health emergency services;

B. how coordination with the PCP, the SE (if applicable) and the hospitalist shall occur when an ISHCN is hospitalized;

C. ensuring that the emergency room physician has access to the individual's medical clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.307.15.15 NMAC]

8.307.15.16 REHABILITATION THERAPY SERVICES (PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY) FOR ISHCN: The CLTS MCO shall:

A. develop and implement therapies using clinical practice guidelines specific to acute, chronic or long-term conditions of their ISHCN, that meet medical necessity criteria and are based on HSD's children and adult rehabilitation services policy;

B. be knowledgeable about and coordinate with the home and community-based waiver programs and/or the schools regarding other therapy services being provided to the ISHCN in order to avoid duplication of services;

C. involve the ISHCN's family, caregivers, physicians and therapy service providers in identifying issues to be included in the plan of services; and

D. develop and implement utilization prior authorization and continued stay criteria, including time frames, that are appropriate to the chronicity of the member's status and anticipated development process.

[8.307.15.16 NMAC]

8.307.15.17 DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES FOR ISHCN: The CLTS MCO shall:

A. develop and implement a process to permit members utilizing supplies on an ongoing basis to submit a list of supplies to the DME service provider on a monthly basis. The CLTS MCO shall contact the member or the member's legal guardian or caregiver when requested supplies cannot be delivered and make other arrangements, consistent with clinical need;

B. develop and implement a system for monitoring compliance with access standards for DME and medical supplies, and institute corrective action if the service provider is out of compliance; and

C. have an emergency response plan for DME and medical supplies needed on an emergent basis.

[8.307.15.17 NMAC]

8.307.15.18 CLINICAL PRACTICE GUIDELINES FOR PROVISION OF SERVICES TO ISHCN: The CLTS MCO/SE shall develop clinical practice guidelines, practice parameters and other criteria that consider

the needs of ISHCN and provide guidance in the provision of acute and chronic physical and behavioral health care services to this population. The guidelines should be based on professionally accepted standards of practice and national guidelines.
[8.307.15.18 NMAC]

8.307.15.19 UTILIZATION MANAGEMENT FOR SERVICES TO (ISHCN): The CLTS MCO/SE shall develop written policies and procedures to exclude from prior authorization any item of service identified in the course of treatment and/or extend the authorization periodicity for services provided for chronic conditions. There shall be a process for review and periodic update for the course of treatment, as indicated.
[8.307.15.19 NMAC]

8.307.15.20 ADDITIONS TO CONSUMER ASSESSMENT OF HEALTH PLANS SURVEY (CAHPS) FOR ISHCN: The CLTS MCO shall add questions about ISHCN to the most current health plan employer data and information set (HEDIS) CAHPS survey.
[8.307.15.20 NMAC]

8.307.15.21 ISHCN PERFORMANCE MEASURES: The CLTS MCO/SE shall initiate a quality strategy related to ISHCN within its annual quality management plan utilizing a performance measure specific to ISHCN. See 8.307.8 NMAC, *Quality Management*.
[8.307.15.21 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 16 MEMBER TRANSITION OF SERVICES

8.307.16.1 ISSUING AGENCY: Human Services Department
[8.307.16.1 NMAC]

8.307.16.2 SCOPE: This rule applies to the general public.
[8.307.16.2 NMAC]

8.307.16.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.16.3 NMAC]

8.307.16.4 DURATION: Permanent
[8.307.16.4 NMAC]

8.307.16.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.16.5 NMAC]

8.307.16.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.16.6 NMAC]

8.307.16.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.16.7 NMAC]

8.307.16.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.16.8 NMAC]

8.307.16.9 MEMBER TRANSITION OF SERVICES: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall have the resources, policies and procedures in place to ensure continuity of services without disruption in service to members and to assure the service provider of payment. The CLTS MCO/SE shall actively assist members, in particular individuals with special health care needs (ISHCN). Members transitioning from institutional levels of care such as hospitals, nursing homes, or residential treatment facilities back to community services with transition of service needs shall be offered care coordination services as indicated. Medicaid-eligible members may initially receive physical and behavioral health services under fee-for-service (FFS) medicaid prior to enrollment in coordinated long-term services. During the member's medicaid eligibility period, enrollment status with a particular CLTS MCO may change and the member may switch enrollment to a different CLTS MCO. Certain members covered under coordinated long-term services may become exempt and other members may lose their medicaid eligibility while enrolled in a CLTS MCO/SE. A member changing from one CLTS MCO to another CLTS MCO, or from FFS to coordinated long-term services or vice versa shall continue to receive medically necessary services in an uninterrupted manner.

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

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

(2) The CLTS MCO shall have policies and procedures that address the transition into the CLTS MCO of an individual member, including member and provider education about the CLTS MCO and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

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

to avoid delays in member treatment. The CLTS MCO shall have written policies and procedures to facilitate a smooth transition of a member to another CLTS MCO when a member chooses and is approved to switch to another CLTS MCO.

(4) The CLTS MCO/SE shall have policies and procedures regarding provider responsibilities for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the CLTS MCO/SE shall help coordinate for a seamless transition of post-discharge care.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the CLTS MCO shall honor all prior authorizations granted by the human services department (HSD) through its contractors for the first 60 days of enrollment or until the CLTS MCO has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the CLTS MCO. The SE shall honor all prior authorizations for 30 days or until other arrangements can be made.

(2) For members who recently became exempt from coordinated long-term services, HSD shall honor prior authorization of FFS covered benefits granted by the CLTS MCO/SE for the first 30 days under FFS medicaid or until other arrangements for the transition of services have been made. Providers that deliver these services and are eligible and willing to enroll as medicaid FFS providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under FFS, the CLTS MCO shall reimburse the service providers approved by HSD if a donor organ becomes available for the member during the first 30 days of enrollment.

(4) For members who had transplant services approved by the CLTS MCO, HSD shall reimburse the service providers approved by the CLTS MCO if a donor organ becomes available for the member during the first 30 days under FFS medicaid. Service providers who deliver these services shall be eligible and willing to enroll as medicaid FFS providers.

(5) For newly enrolled members, the CLTS MCO shall pay for prescriptions for drug refills for the first 90 days or until the CLTS MCO has made other arrangements. The SE shall pay for all prescriptions for 30 days or until other arrangements are made. All drugs prescribed by a licensed behavioral health service provider shall be paid for by the SE.

(6) For members who recently became exempt from coordinated long-term services, HSD shall pay for prescriptions for drug refills for the first 30 days under the FFS formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid FFS provider.

(7) The CLTS MCO shall pay for durable medical equipment (DME) costing $2,000 or more, approved by the CLTS MCO but delivered to the member after disenrollment from coordinated long-term services.

(8) HSD shall pay for DME costing $2,000 or more, approved by HSD but delivered to the member after enrollment in the CLTS MCO. The DME service provider shall be eligible for and willing to enroll as a medicaid FFS provider. DME is not covered by the SE unless it has been prescribed by a behavioral health service provider.

C. **Special payment requirement:** The CLTS MCO shall be responsible for payment of covered physical health services provided to the member for any month during which the CLTS MCO receives a capitation payment. The SE shall be responsible for payment of covered behavioral health services provided to the member for any month the SE receives a capitation payment.

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

(1) The CLTS MCO/SE shall be required to inform service 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 service 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 CLTS MCO/SE shall allow six months to process claims for services provided prior to the contract termination date.

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

[8.307.16.9 NMAC]

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG-TERM SERVICES
PART 17 VALUE ADDED SERVICES

8.307.17.1 ISSUING AGENCY: Human Services Department
[8.307.17.1 NMAC]

8.307.17.2 SCOPE: This rule applies to the general public.
[8.307.17.2 NMAC]

8.307.17.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.307.17.3 NMAC]

8.307.17.4 DURATION: Permanent
[8.307.17.4 NMAC]

8.307.17.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.17.5 NMAC]

8.307.17.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid coordinated long-term services program.
[8.307.17.6 NMAC]

8.307.17.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.17.7 NMAC]

8.307.17.8 MISSION STATEMENT: The mission of the medical assistance division is to ensure access to quality and cost-effective health care.
[8.307.17.8 NMAC]

8.307.17.9 VALUE ADDED SERVICES: The coordinated long-term services managed care organization (CLTS MCO) and single statewide entity (SE) shall offer members value added services. The cost of these services cannot be included when the human services department (HSD) determines the payment rates. Value added services are not included in the medicaid coordinated long-term services benefit package. Value added services shall not be construed as medicaid funded services, benefits, or entitlements under the NM Public Assistance Act. Value added services shall be approved by and reported to HSD or its designee. The CLTS MCO/SE shall work with HSD or its designee to identify codes to be used for value added services. Value added services shall be direct services, and not administrative in nature unless approved by HSD or its designee.

A. **Potential value added services (CLTS MCO only):** The following are suggested value added services:

(1) anticipatory guidance provided as a part of the normal course of office visits or a health education program, including behavioral health;
(2) abuse and neglect prevention programs;
(3) stress control programs;
(4) culturally-traditional indigenous healers and treatments;
(5) smoking cessation programs;
(6) weight loss and nutrition programs;
(7) violence prevention services;
(8) service animals, assistive technology that is beyond the benefit package, and pest control; and
(9) substance abuse prevention and treatment, beyond the benefit package.

B. **Potential value added services (SE only):** The SE shall strategically determine a continuum of services, identify value added services needs and work with the collaborative to develop value added services. Value added services should promote evidence based practices that support recovery and resiliency.

C. **Member specific value added services:** Other services may be made available to members based on the CLTS MCO's/SE's discretion. Eligibility for value added services may be based upon a set of assessment criteria to be employed by the CLTS MCO/SE.
[8.307.17.9 NMAC]