State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
MEDICAID MANAGED CARE

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Medical Assistance Division is proposing amendments to the Medicaid managed care rules to reflect additional program requirements, suggestions from the Legislative Finance Committee, and to clarify language related to Medicaid managed care policy.

VI. REGULATIONS
These proposed regulation changes refer to 8.305 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 July 1, 2009.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 9:00 AM on May 12, 2009, in the Rio Grande Room of the Toney Anaya Building, 2550 Cerrillos Road in Santa Fe.

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 PM on May 12, 2009. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons my also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

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

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 1 GENERAL PROVISIONS

8.305.1.7 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 capitated managed care plan has been implemented. This section contains the glossary for the New Mexico medicaid managed care 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) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) or the single statewide entity (SE) for behavioral health of an MCO or SE action as defined above in Paragraph (2) of Subsection A of 8.305.1.7 NMAC.

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

(5) **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.

(6) **Assignment algorithm:** Predetermined method for assigning mandatory enrollees who do not select an MCO.

B. Definitions beginning with letter "B":

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

(2) **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.

(3) **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.

(4) **Benefit package:** Medicaid covered services that must be furnished by the 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 an 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) **Care coordination for behavioral health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family, if appropriate. Care coordination operates independently within the SE and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other SE systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the behavioral health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the consumer's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Care coordination for physical health:** An office-based administrative function to assist members with multiple, complex and special cognitive, behavioral or physical health care needs on an as needed basis. It is member-centered and consumer-directed, family-focused when appropriate, culturally competent and strengths-based. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the member and family if appropriate. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff, but is structurally linked to other MCO systems, such as quality assurance, member services and grievances. Clinical decisions shall be based on the medically necessary covered services and not fiscal or administrative considerations. The care coordinator coordinates services within the physical health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, if applicable, for those who receive case management services. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(4) **Care coordination plan/individual plan of care (SE only):** The care coordination plan is based on a comprehensive assessment of the goals, capacities and the behavioral health service needs of the member and with consideration of the needs and goals of the family, if appropriate.

(5) **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.

(6) **Case management for physical health:** The targeted case management programs, that are part of the medicaid benefit package. The 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, coordinate, advocate for and link members to all needed services related to the targeted case management program.

(7) **Children with special health care needs (CSHCN):** Individuals under 21 years of age, who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.

(8) **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.

(9) **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".

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

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

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

(14) **[~~Coordinated~~]Coordination of long-term services [~~(CLTS)~~] (CoLTS):** 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) home and community-based waivers. The [~~CLTS~~] CoLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The [~~CLTS~~] CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities, AIDS and medically fragile waiver programs.

(15) **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 and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

(1) **Delegation:** A formal process by which an MCO/SE gives another entity the authority to perform certain functions on its behalf. The 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 MCO/SE formulary or due to provider noncompliance with administrative policies and procedures established by either the 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 process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

(5) **Disenrollment, MCO initiated:** When requested by an MCO for substantial reason, removal of a medicaid member from membership in the requesting 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 MCO to a different 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 an MCO/SE member, client, customer, or consumer.

(3) **Enrollee:** A medicaid recipient who is currently enrolled in a managed care organization in a given managed care program.

(4) **Enrollee rights**: Rights which each managed care enrollee is guaranteed.

(5) **Enrollment:** The process of enrolling eligible clients in an MCO/SE for purposes of management and coordination of health care delivery.

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

(7) **Exempt:** The enrollment status of a client who is not mandated to enroll in managed care.

(8) **Exemption:** Removal of a medicaid member from mandatory enrollment in managed care 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 MCO/SE of an 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 a 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 provider after services are rendered and billed.

(4) **Fraud:** An intentional deception or misrepresentation made by an entity or person, including but not limited to, an 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.

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

G. Definitions beginning with letter "G":

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

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

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO/SE expressing dissatisfaction with any aspect of the MCO/SE or its operations that is not an 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) **HIPAA:** Health Insurance Portability and Accountability Act of 1996.

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

(5) **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 MCO/SE has incurred financial liability, but the claim has not been received by the MCO/SE. This estimating method relies on data from prior authorization and referral systems, other data analysis systems and accepted accounting practices.

(2) **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 - L: [RESERVED]

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 includes brochures, leaflets, internet, newspaper, magazine, radio, television, billboard materials, MCO/SE yellow page advertisements, and any other presentation materials used by an MCO/SE, MCO/SE representative, or MCO/SE subcontractor to attract or retain medicaid enrollment.

(3) **MCO/SE:** The use of MCO/SE in these medicaid managed care regulations indicates the following regulation applies to both the MCO and the SE who must each comply with the regulation independent of each other.

(4) **MCO/SE mandatory enrollee:** A client whose enrollment into an MCO/SE is mandated.

(5) **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.

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

(7) **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 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.

(8) **Member:** A client enrolled in an MCO/SE.

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

(10) **Mi via home and community-based waiver:** The New Mexico self-directed medicaid waiver program that supports New Mexicans with disabilities and the elderly by allowing recipients to be active participants in choosing where and how they live and what services and supports they purchase.

N. Definitions beginning with letter "N":

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

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

O. [RESERVED]

P. Definitions beginning with letter "P":

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

(2) **Performance improvement project (PIP):** An 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.

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

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

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

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

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

(8) **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.

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

(10) **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.

(11) **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 state option, any of the following:

(a) a physician assistant;

(b) a nurse practitioner; or

(c) a certified nurse mid-wife.

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

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

Q. [RESERVED]

R. Definitions beginning with letter "R":

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

(2) **Received but unpaid claims (RBUC):** Claims received by the MCO/SE but not paid affecting appropriate expense and aging accounting categories. Such claims are counted as of the date of receipt by the 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 an 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 the MCO/SE will not be sufficient to cover expenditures incurred in the delivery of contractual services.

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

S. Definitions beginning with letter "S":

(1) **Salud!;** the New Mexico managed care program implemented in 1997, covering children, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children are also covered by medicaid if they met eligibility requirements.

[~~(1)~~] (2) **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 proposal (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 of service delivery and conducting any other administrative functions necessary to achieve the goals of the collaborative. The SE is the agent of the collaborative and shall "coordinate", "braid" or "blend" the funding, human resources and service capacity available from the various state agencies so as to increase flexibility, maximize available resources and create a seamless single behavioral health service delivery system for New Mexico.

[~~(2)~~] (3) **Subcontract:** A written agreement between the MCO/SE and a third party, or between a subcontractor and another subcontractor, to provide services.

[~~(3)~~] (4) **Subcontractor:** A third party who contracts with the MCO/SE or an MCO/SE subcontractor for the provision of services.

T. Definitions beginning with letter "T":

(1) **Targeted case management:** Services that are aimed specifically at special groups of members like adults with developmental disabilities.

[~~(1)~~] (2) **Terminations of care:** The utilization management review decision made during a concurrent review, which yields a denial, based on the current service being no longer medically necessary.

[~~(2)~~] (3) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for medicaid members for services furnished under a state plan.

(4) **Transition of care:** The process when a member is assisted with access to necessary care when the member moves from one health care practitioner or setting to another as their condition and care needs change.

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

V. Definitions beginning with letter "V": **Value added service:** Any service offered to members by the MCO/SE that is not included in the managed care medicaid benefit package and is not a medicaid funded service, benefit or entitlement under the NM Public Assistance Act.

[8.305.1.7 NMAC - Rp 8.305.1.7 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 2 MEMBER EDUCATION

8.305.2.9 MEMBER EDUCATION: Medicaid members shall be educated about their rights, responsibilities, service availability and administrative roles under the managed care program. Member education is initiated when a member becomes eligible for medicaid and is augmented by information provided by HSD and the managed care organization (MCO) or the single statewide entity [~~SE~~] (SE).

A. **Initial information:** The education of the member is initiated by the eligibility determination agencies. HSD distributes information about medicaid managed care and the enrollment process to these agencies.

B. **MCO/SE enrollment information:** Once a member is determined to be an MCO/SE mandatory enrollee, HSD will provide to the member information about services included in the MCO/SE benefit package, and the MCOs from which the member can choose to enroll as a member.

C. **Informational materials:** The MCO/SE is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in formats other than English. If there is a prevalent population of 5% within the MCO/SE membership, as determined by the MCO/SE or HSD, these materials shall be made available in the language of the identified prevalent population.

(1) The MCO member handbook must 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 by and with PCPs (within the MCO/SE) as well as information pertaining to transition of care (between the MCOs);

(e) how to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services;

(f) [~~description~~] the amount, duration and scope of mandatory benefits;

(g) information on accessing behavioral health or other specialty services, including a discussion of the member's rights to self-refer to in-plan and out-of-plan family planning providers and a female member's right to self-refer to a women's health specialist within the network for covered care;

(h) limitations to the receipt of care from out-of-network providers;

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

(j) a policy on referrals for specialty care and other benefits not furnished by the member's PCP;

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

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

(m) information regarding advance directives;

(n) information regarding obtaining a second opinion;

(o) information on cost sharing, if any;

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

(q) populations excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; [~~and~~]

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

(s) language that clearly explains that a Native American Salud! member may self refer to an Indian health service or a Tribal health care facility for services.

(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;

(i) 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;

(o) language that clearly explains that a Native American Salud! member may self refer to an Indian health service or a Tribal health care facility for services; and

(p) information regarding the birthing option plan.

(3) The provider directory must include the following:

(a) MCO/SE addresses and telephone numbers;

(b) MCO: a listing of primary care and self-refer specialty providers with the identity, location, phone number, and qualifications to include area of special expertise and non-English languages spoken that would be helpful to individuals. MCO contracted specialty providers for self-referral shall include, but not be limited to, [~~family planning providers,~~] urgent and emergency care providers, and Indian health service[~~,~~] and Tribal health care [~~other Native American~~] providers [~~and pharmacies~~] including hospitals, outpatient clinics, pharmacies and dental clinics;

(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 including Indian health service and Tribal behavioral health providers; 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 MCO/SE shall provide to enrolled members the member handbook and provider directory within 30 calendar days of enrollment.

(2) The handbook and directory shall be provided, in a comprehensive, understandable format that takes into consideration the special needs population, and is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *Member Bill Of Rights*. This information may also be accessible via the internet, and be provided as requested by HSD. The MCO/SE shall have a process in place for notifying potential members and members of the availability of this information in alternate formats.

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

(4) The member handbook shall be approved by HSD prior to distribution to medicaid members. The SE's behavioral health member (or consumer) handbook shall be approved by HSD or its designee prior to distribution [~~by HSD or its designee~~].

(5) Notification of material changes in the administration of the MCO/SE, changes to the MCO's/SE's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD shall be distributed to the members 30 days prior to the intended effective date of the change. In addition, the 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.

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

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

E. **MCO/SE policies and procedures on member education:** The 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 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 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 shall not approve health education materials. The 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 MCO/SE shall maintain one or more toll-free telephone lines which are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. MCO/SE members may also leave voice mail messages to obtain other MCO/SE policy information and to register grievances with the MCO/SE. The MCO/SE shall return the telephone call by the next business day.

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

[8.305.2.9 NMAC - Rp 8.305.2.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 3 CONTRACT MANAGEMENT

8.305.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS (MCO) AND THE BEHAVIORAL HEALTH SINGLE STATEWIDE ENTITY (SE): The human services department (HSD) shall award risk-based contracts to MCOs and a contract to the single SE with statutory authority to assume risk and enter into prepaid capitation agreements, which 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 MCOs/SE 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 proposal in conformity with the requirements specified in the request for proposal. The behavioral health collaborative shall award a contract to a single statewide entity ~~(SE~~ (SE) to deliver medicaid behavioral health services to medicaid members.

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 managed care contract. [8.305.3.9 NMAC - Rp 8.305.3.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.3.10 CONTRACT MANAGEMENT: HSD is responsible for management of the medicaid contracts issued to MCOs/SE. HSD shall provide the oversight and administrative functions to ensure 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 MCO/SE shall meet all specified terms of the medicaid contract with HSD and the collaborative as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO/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 MCO/SE may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO/SE functions with HSD's approval. The MCO/SE shall submit boilerplate contract language and sample contracts for various types of subcontracts for HSD's approval. Any substantive changes to contract templates shall be approved by HSD or the collaborative prior to issuance. 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 MCO/SE shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards. The MCO/SE shall assure the prospective subcontractor's ability to perform the activities to be delegated.

(2) **Review requirements:** The MCO/SE shall maintain a fully executed original of all subcontracts and make them accessible to HSD [~~on~~] upon request.

(3) **Minimum requirements (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 [~~operation~~] operate in the state of New Mexico;

(c) subcontracts shall include [~~procedures and criteria for terminating the subcontract~~] the frequency of reporting (if applicable) to the MCO/SE and the process by which the MCO/SE evaluates the delegate;

(d) subcontracts shall identify the services to be performed by the subcontractor and the services to be performed under other subcontracts; subcontracts must describe how members access services provided under the subcontract;

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

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

(g) subcontracts shall require that member information be kept confidential, as defined by

federal or state law, and be HIPAA compliant;

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

(i) subcontracts shall include a provision for the subcontractor to release to the MCO/SE any information necessary to perform any of its obligations;

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

(k) if subcontracts include primary care, provisions for compliance with PCP requirements delineated in the MCO contract with HSD apply;

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

(m) subcontracts shall have procedures and criteria for terminating the subcontract, a provision for the imposition of sanctions for inadequate subcontractor performance, and terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

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

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

(p) subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise [~~protecting member's interests~~] act to protect members' interests;

(q) subcontracts shall specify the time frame for submission of encounter data to the MCO/SE;

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

(s) subcontracts shall include a provision requiring subcontractors to perform criminal background checks, as required by law, for all individuals providing services;

(t) (MCO only) subcontracts shall include a provision requiring providers to submit claims electronically; low volume or low dollar providers may have this requirement waived; and

(u) subcontracts shall include the HSD contractual provisions of the State of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements.

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

[8.305.3.10 NMAC - Rp 8.305.3.10 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO/SE shall provide the following information to HSD and updates, modifications, or amendments to HSD 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 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 MCO's/SE's relationship to parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

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

(1) **Review of policies and procedures:** The MCO/SE shall review the MCO's/SE's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's/SE's 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.

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

(3) **Business requirements:** The MCO/SE shall have the administrative, information and other systems in place necessary to fulfill the terms of the medicaid managed care contracts. Any change in identified key MCO/SE personnel shall conform to the requirements of the managed care contract. The MCO/SE shall retain financial records, supporting documents, statistical records, and all other records for a period of 10 years from the date of submission of the final expenditure report, except as otherwise specified in writing by HSD.

(4) **Financial requirements:** The 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 MCO/SE shall meet additional financial requirements specified in the contract.

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

(6) **Consumer advisory board:** The MCOs and the SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and 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 MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. If the formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members, the MCO shall include at least three SCI members in the Salud! consumer advisory board meetings.

(a) The MCO consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. The SE consumer advisory board members shall serve to advise the SE on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. [~~The MCO and the SE board shall meet at least quarterly and keep a written record of meetings.~~] The MCO/SE shall hold quarterly, centrally located meetings every year. The [~~board~~] attendance roster and minutes shall be made available to HSD on request. The [~~MCO~~]MCO/SE shall advise HSD 10 days in advance of meetings to be held. HSD shall attend and observe the [~~MCOs'~~] MCO's consumer advisory board meetings at their discretion. HSD shall attend and observe the SE's consumer advisory board meetings at its discretion.

(b) The SE shall attend at least two statewide consumer driven or hosted meetings per year, of the SE's choosing, that focus on consumer issues and needs, to ensure that members' concerns are heard and addressed. The MCO will hold at least two additional statewide consumer advisory board meetings each contract year that focus on consumer issues to help ensure that consumer issues and concerns are heard and addressed. Attendance rosters and minutes for these two statewide meetings shall be made available to HSD.

(7) **Requirements for Native American membership:** Per HSD direction, the MCO shall hold at least one annual meeting with Native American representatives from around the state of New Mexico that represent geographic and member diversity. The minutes of such meetings shall be submitted to HSD within thirty days of such meetings.

[~~(7)~~] (8) **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

(a) require plans of correction;

(b) impose directed plans of correction;

(c) impose 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 MCO/SE, including an assessment of a monetary penalty against the 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, or the severity or degree of harm posed to or incurred by members or the integrity of the medicaid program;

(iii) a monetary penalty, depending upon the severity of the infraction; penalty assessments shall range up to 5% of the MCO's/SE's medicaid capitation payment for each 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 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 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 care providers; failure to comply with physician incentive plan requirements; and marketing violations;

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

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

(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 MCO/SE;

(i) deny payment;

(j) assess actual damages;

(k) assess liquidated damages;

(l) remove members with third party coverage from enrollment with the MCO/SE;

(m) allow members to terminate enrollment;

(n) suspend agreement;

(o) terminate MCO/SE contract;

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

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

(i) there is continued egregious behavior by the 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 Sections 1396b(m) or 1396u-2; or

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

(iii) the sanction is necessary to ensure the health and safety of the 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 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 MCO/SE can ensure that the sanction behavior will not re-occur; refer to state and federal regulations for due process procedures.

[8.305.3.11 NMAC - Rp 8.305.3.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 4 MANAGED CARE ELIGIBILITY

8.305.4.9 MANAGED CARE ELIGIBILITY: HSD determines eligibility for enrollment in the managed care program. All medicaid eligible clients are required to participate in the medicaid managed care program except for the following:

A. clients eligible for both medicaid and medicare (dual eligibles);

B. institutionalized clients, defined as those expected to reside in a nursing facility for long term care or permanent placement; this does not include clients placed in a nursing facility to receive subacute or skilled nursing care in lieu of continued acute care;

C. clients residing in intermediate care facilities for the mentally retarded;

D. clients participating in the health insurance premium payment (HIPP) program;

E. children and adolescents in out-of-state foster care or adoption placements;

F. Native Americans;

G. clients eligible for medicaid category 029, family planning services only;

H. women eligible for medicaid category 052, breast and cervical cancer program, [~~and members approved for the disabled and elderly home and community-based waiver~~];

I. adults ages 19-64 eligible for category 062, state coverage insurance;

J. members with brain injury COE 092; [~~and~~]

K members approved for adult personal care options (PCO) services; and

L. members approved for the disabled and elderly home and community-based waiver, categories 091, 093 and 094.

[8.305.4.9 NMAC - Rp 8 NMAC 4.MAD.606.3.1, 7-1-01; A, 7-1-02; A, 7-1-04; A, 7-1-05; A, 7-1-08; A, 7-1-09]

8.305.4.10 SPECIAL SITUATIONS:

A. **Newborn enrollment:** The following provisions apply to newborns:

(1) Medicaid eligible and enrolled newborns of medicaid eligible enrolled mothers are eligible for a period of 12 months starting with the month of birth. These newborns are enrolled retroactive to the date of birth with the same MCO the mother had during the birth month, as soon as the newborn's eligibility is approved, regardless of where the child is born (that is, in the hospital or at home). The MCO is responsible for care of a newborn to a Salud! enrolled mother, whose eligibility is determined through daily rosters provided by [~~HSD/MAD~~] HSD or by the MCO's required follow-up of the MAD 313 form.

(2) If the newborn's mother is not a member of the MCO at the time of the birth in a hospital or at home, the newborn must be medicaid enrolled and shall be MCO enrolled during the next applicable enrollment cycle.

B. **Hospitalized members:** Regarding Salud! MCO and medicaid fee-for-service (FFS) members: If an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, [~~with the exception of a member transferring to CLTS,~~] the originating MCO or FFS shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the 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 or FFS in the case of disenrollment from Salud! Regarding Salud!MCO and CoLTS MCO members: For members transitioning to [~~CLTS~~] CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE. This does not apply to newborns born to a member mother, see Subsection A of 8.305.4.10 NMAC above. Transition services, e.g., DME supplies for the home, shall be the financial responsibility of the MCO or the SE, if applicable to behavioral health receiving capitation payments. The originating and receiving organization are both required to ensure continuity and coordination of care during the transition.

C. **Native Americans:** A self-identified Native American shall be afforded the option of participating in managed care or being covered by medicaid fee-for-service for medical or behavioral health

services. Upon determination of medicaid eligibility, a Native American may choose to participate in managed care, or opt in, by enrolling in an MCO for medical services or by choosing the managed care SE for behavioral health services. By not enrolling in an MCO or not choosing the managed care SE, the Native American chooses not to participate in managed care and shall be covered through medicaid fee-for-service. A medicaid eligible Native American may opt-in at any time by enrolling with an MCO or by choosing the managed care SE. If an opt-in request is made prior to the 20th of the month, the opt-in shall become effective the following month. If the opt-in request is made after the 20th of the month and before the first day of the next month, the opt-in shall be effective on the first day of the second full month following the request. After enrolling in an MCO or the managed care SE, a Native American may opt out during the first 90 days of any 12-month enrollment lock-in period (disenrollment). Disenrollment is effective the following month. At the end of the lock-in period, a Native American may choose to either continue enrollment in managed care or opt-out of managed care.

D. **Members receiving hospice services:** Members who have elected to receive hospice services and are receiving hospice services at the time they are determined eligible for medicaid will be exempt from enrolling in managed care unless they revoke their hospice election.

E. **Members placed in nursing facilities:** If a member is placed in a nursing facility for what is expected to be a long term or permanent placement, the MCO or the SE, remains responsible for the member until the member is disenrolled [~~by HSD~~] from Salud! and enrolled into the CoLTS program at the time that the nursing facility determination (the approved abstract) is entered into the MMIS system. Failure of a nursing facility to maintain abstract authorization for an institutionalized member that causes the system to enroll the member into managed care is considered an error in enrollment. The MCO/SE is not responsible for payment of any medical or behavioral services delivered and all capitations shall be recouped.

F. **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 8.305.11.9 NMAC for special payment requirements.

G. **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 MCO/SE remains responsible for the member until the member is disenrolled by HSD.

[~~H. In compliance with federal law and authorizations, HSD may mandate that a member eligible for medicaid and medicare (dual eligibles) shall be enrolled with an MCO/SE to receive benefits from the medicaid benefit package that are not provided by medicare. This program will be implemented in compliance with federal law and requirements.~~]

[8.305.4.10 NMAC - Rp 8 NMAC 4.MAD.606.3.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 5 ENROLLMENT IN MANAGED CARE

8.305.5.9 ENROLLMENT PROCESS.

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO shall accept eligible individuals in the order in which they apply without restriction, unless authorized by the CMS regional administrator, up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The 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. All enrollments in a specific MCO shall be member choice. 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 [~~14~~] at least 16 calendar days to select an MCO. If a selection is not made [~~in 14 days~~], the member shall be assigned to an MCO by HSD. Members mandated into managed care shall be automatically assigned to the SE.

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

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

(2) **Enrollment based on case continuity:** Enrollment based on case continuity is applied in the following manner:

(a) **Processing case continuity:** The member is enrolled with the MCO to which the majority of the case (family) members is assigned. If an equal number of case (family) members are assigned to different MCOs and a majority cannot be identified, the member is assigned to an MCO to which other case (family) members are assigned.

(b) **Newborn enrollment:** [~~A newborn whose mother is a member in an MCO is automatically enrolled in the mother's MCO and in the SE.~~] When a child is born to a mother enrolled with a Salud! contractor, hospitals or other providers shall complete a Notification of Birth, MAD Form 313. The newborn remains enrolled with the mother's MCO until the mother selects a new MCO for the child.

(3) **Percentage-based assignment (assignment algorithm):** As determined by HSD, members who are not enrolled using the previous methods may be enrolled in an MCO using a percentage-based assignment process. The percentage-based assignments for each MCO may be determined based upon consideration of the MCO's performance in such areas as the quality assurance standards, encounter data submissions, reporting requirements, third party liability collections, marketing plan, community relations, coordination of service, grievance resolution, claims payment, price 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) newborn enrollment, (Subsection A of 8.305.4.10 NMAC, *newborn enrollment*); and

(2) members receiving hospice care, (Subsection E of 8.305.4.10 NMAC, *members receiving hospice services*);[~~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. **Member lock-in:** Member enrollment in an MCO runs for a 12-month cycle. During the first 90 days after a member initially selects or is assigned to an MCO, the member shall have the option to choose a different MCO to provide care during the member's remaining period of managed care enrollment.

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

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

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

(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 60 days prior to the expiration date of the member's lock-in period of the expiration of the lock-in and the deadline by when to choose a new MCO.

(5) If a member loses medicaid eligibility for a period of two months or less, he will be automatically reenrolled with the former MCO. If the member misses the annual disenrollment opportunity during this two-month time, he may request to be assigned to another MCO.

F. **Member switch enrollment:** A member who is required to enroll in managed care may request to be disenrolled from an MCO and switch to another MCO "for cause" at any time. The member or his representative shall make the request in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO no later than the first day of the second month following the month in which the member or his 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 care issues;

(2) family continuity;

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

(6) the 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, not all related services can be provided by the PCP, and another 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 care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.

G. **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 physical health and behavioral health services for cause on a case-by-case basis. If the exemption is granted, the member shall receive his/her behavioral health services through the SE under the medicaid fee-for-service (FFS) program and his/her physical health services under the medicaid FFS program. A member or the member's representative, parent or legal guardian 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 managed care at the time of the exemption request, shall remain exempt until a final determination is made. A member already in managed care at the time of the exemption request shall remain in managed care 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.

H. **Disenrollment, MCO/SE initiated:** The MCO/SE may request that a particular member be disenrolled from managed care. Member disenrollment from an 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 8.305.5.9 NMAC. The 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 his special needs (except when his continued enrollment with the MCO/SE seriously impairs the MCO's or SE's ability to furnish services to either this particular member or other members). The MCO/SE shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO/SE shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO/SE retains responsibility for the member's care until the member is enrolled with another MCO or exempted from managed care. In the case of the SE, the member would be exempted from the SE medicaid managed care and would receive behavioral health benefits under the medicaid fee-for-service (FFS) program. The MCO/SE shall assist with transition of care.

I. **Conditions under which an MCO/SE may request member disenrollment:** Conditions under which an MCO/SE may request disenrollment are:

(1) the MCO/SE demonstrates 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 MCO/SE to safely or prudently provide medical or behavioral health care subject to the terms of the contract;

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

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

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

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

[8.305.5.9 NMAC - Rp 8.305.5.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

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

[8.305.5.11 NMAC - Rp 8.305.5.14 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.5.12 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one 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 MCO identification number or MCO name; and

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

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

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

D. **Mass transfer based on maintenance:** The mass transfer maintenance function may be triggered when the medicaid or managed care status change of the MCO is transparent to the member. For instance, a change in the 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 MCO. Upon initiation of the maintenance function by HSD, members are automatically transferred to the prior MCO experiencing the maintenance change.

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

[8.305.5.12 NMAC - Rp 8.305.5.15 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.5.13 MEDICAID MANAGED CARE AND SINGLE STATEWIDE ENTITY MARKETING GUIDELINES: When marketing to medicaid members, the MCOs/SE shall follow the medicaid managed care marketing guidelines.

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

(1) marketing and outreach materials must meet requirements for all communication with medicaid

members, as delineated in the quality standards (8.305.8.15 NMAC, *member bill of rights*) and incorporated into the managed care contract;

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

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

(4) if there is a prevalent population of 5% in the MCO/SE membership that has limited English proficiency, as identified by the 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, MCO/SE yellow page advertisement, web site, press releases, telephone scripts and presentation materials used by an MCO/SE, [~~and~~] an MCO/SE representative or an MCO/SE sub-contractor to attract or retain medicaid enrollment. HSD may request, review and approve or disapprove any communication to any medicaid member. HSD may request, review and approve or disapprove any communication to any medicaid member regarding behavioral health. The MCO/SE [~~are~~] is 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 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 MCO/SE's 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 sub-contractor 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 MCO/SE strengths:** Misleading information shall not be allowed even if it is accurate. For example, an MCO/SE may seek to advertise that its health care services, including behavioral health, 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 MCO/SE. In other words, they might believe they would have to pay for medicaid health services if they chose another MCO or remained in fee-for-service medicaid.

(3) **Threatening messages:** An MCO/SE shall not imply that another managed care or other behavioral health program is endangering members' health status, personal dignity or the opportunity to succeed in various aspects of their lives. An MCO/SE 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 means of communication) or whether the activity is performed by the MCO/SE directly, its network providers, its subcontractors or any other party affiliated with the MCO/SE. HSD shall prohibit additional marketing activities at its discretion.

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

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

(3) initiating an enrollment request on behalf of a medicaid member except under circumstances in which the MCO, its representative, network provider or subcontractor may perform presumptive eligibility screening or Medicaid onsite application assistance as an agent of the state;

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

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

(6) the use of more than nominal gifts such as diapers, toasters, infant formula or other incentives to

entice medicaid members to join a specific health plan;

(7) telemarketing or door-to-door 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 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 telephone or other cold call marketing activities, directly or indirectly; and

(13) other requirements specified by HSD [~~;~~

~~(14) initiating an enrollment request on behalf of a medicaid recipient except under circumstances in which the MCO, its representative, network provider or subcontractor may perform presumptive eligibility screening or medicaid on site application assistance as an agent of the state~~].

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

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

G. **Member-initiated meetings with MCO/SE staff prior to enrollment:** Face-to-face meetings requested by a member are permitted. These meetings may occur at a mutually agreed upon site. All verbal interaction with the member must be in compliance with the guidelines identified in these regulations.

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

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

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

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

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

[8.305.5.13 NMAC - Rp 8.305.5.16 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 6 PROVIDER NETWORKS

8.305.6.9 GENERAL NETWORK REQUIREMENTS: The MCO/SE shall establish and maintain a comprehensive network of providers willing and capable of serving members enrolled with the MCO/SE.

A. **Service coverage:** The MCO/SE shall provide or arrange for the provision of services described in 8.305.7 NMAC, *Benefit Package*, in a timely manner. The 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 MCO/SE shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO/SE shall contract with a number of providers sufficient to maintain equivalent or better access than that available under medicaid fee-for-service. The MCO/SE shall take into consideration the characteristics and health care needs of its individual medicaid populations. The MCO/SE must contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the MCO/SE shall consider the following:

(1) the numbers of network providers who are not accepting new medicaid members, as identified by checking the open/closed panel status;

(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 MCO/SE shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members' access or the [~~MCO/SE's~~] MCO's/SE's ability to deliver services included in the benefit package in a timely manner. The MCO/SE shall regularly update open and closed panel status and post this information on their website. Anticipated material changes in an MCO/SE provider network shall be reported to HSD in writing within 30 days prior to the change, or as soon as the MCO/SE knows of the anticipated change. A notice of significant 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 [~~MCO/SE's~~] MCO's/SE's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO/SE shall maintain policies and procedures on provider recruitment and termination of provider participation with the MCO/SE. The recruitment policies and procedures shall describe how an MCO/SE responds to a change in the network that affects access and its ability to deliver services in a timely manner. The 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 practitioners 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 or entities excluded from participation in federal health care programs because of misconduct; and

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

E. **General information submitted to HSD:** The MCO shall maintain an accurate unduplicated list of contracted, subcontracted and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the 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 MCO/SE shall submit a list to HSD on a regular basis, as determined by HSD, and include a clear delineation of all additions and terminations that have occurred since the last submission.
[8.305.6.9 NMAC - Rp 8 NMAC 4.MAD.606.5.1, 7-1-01; A, 7-1-03; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

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

A. **Primary care responsibilities:** The 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 care;

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

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

(4) 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 MCO to vaccinate members in their offices and not refer members elsewhere for immunizations; the MCO 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 his age group;

(7) ensuring that care is coordinated with other types of health and social program providers, including but not limited to behavioral health, including mental health and substance abuse, the women, infants and children program (WIC), children, youth, and families department (CYFD), adult and child protective services and juvenile justice division;

(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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) **Pharmacy lock-in:** HSD shall allow the MCO/SE to require that a member see a certain pharmacy provider when member compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO/SE shall inform the member or his/her representative of the intent to lock-in. The MCO's/SE's grievance procedure shall be made available to the member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the MCO/SE and reported to HSD every quarter. The member shall be removed from pharmacy lock-in when the MCO/SE has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all lock-in removals.

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

[8.305.6.12 NMAC - Rp 8 NMAC 4.MAD.606.5.4, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-09]

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

[8.305.6.18 NMAC – N, 7-1-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 7 BENEFIT PACKAGE

8.305.7.11 SERVICES INCLUDED IN THE MEDICAID BENEFIT PACKAGE:

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

B. **Transplant services (MCO only):** 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 detailed 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.

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

D. **Case management services (MCO):** The benefit package includes case management services necessary to meet an identified service need as detailed in 8.326.2 NMAC through 8.326.6 NMAC and 8.320.5 NMAC.

E. **Specific case management programs:** The following are specific case management programs available to medicaid members within the MCO, which meet the requirements specified in policy manual parts:

(1) **case management services for adults with developmental disabilities (MCO only):** Case management services provided to adult members (21 years of age or older) who are developmentally disabled, as detailed in 8.326.2 NMAC, *Case Management Services for Adults with Developmental Disabilities*;

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

(3) **case management services for traumatically brain injured adults (MCO only):** Case management services provided to adults who are 21 years of age or older who are traumatically brain injured, as detailed in 8.326.5 NMAC, *Case Managed Services for Traumatically Brain Injured Adults*;

(4) **case management services for children up to the age of three (MCO only):** Case management services for 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

(5) **case management services for the medically at risk (MCO only):** Case management services for individuals who are under 21 who are medically at risk for physical or behavioral health conditions, as detailed in 8.320.5 NMAC, *EPSDT Case Management*; the benefit package does not include case management provided to developmentally disabled children ages 0-3 who are receiving early intervention services, or case management services provided by the children, youth and families department and defined as protective services case management or juvenile probation and parole officer case management; "medically at risk" is defined as those individuals who have a diagnosed physical or behavioral health condition which has a high probability of impairing their cognitive, emotional, neurological, social, behavioral or physical development.

F. **Emergency services (MCO/SE):** The benefit package includes inpatient and outpatient services meeting the definition of emergency services. It is the responsibility of the MCOs to cover emergency room facility costs even when the primary diagnosis is a behavioral health diagnosis, with the exception of UNM psychiatric emergency room, which will be the responsibility of the SE. Services shall be available 24 hours per day and 7 days per week. Services meeting the definition of emergency services shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO/SE. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize

an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain this stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO/SE has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO/SE; or

(2) the hospital contacted the MCO/SE but did not get instructions within an hour of the request.

G. **Physical health services (MCO only):** The benefit package includes primary (including those provided in school-based settings) and specialty physical health services provided by a licensed practitioner performed within the scope of practice, as defined by state law and detailed in 8.310.2 NMAC, *Medical Services Providers*; 8.310.10 NMAC, *Midwife Services*, including 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 validly contracted with and fully credentialed by the MCO or validly contracted with HSD 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*.

H. **Laboratory services (MCO or SE):** The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA), as detailed 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 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 the MCO.

I. **Diagnostic imaging and therapeutic radiology services (MCO or SE):** The benefit package includes medically necessary diagnostic imaging and radiology services, as detailed 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 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 MCO.

J. **Anesthesia services (MCO):** The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures, as detailed in 8.310.5 NMAC, *Anesthesia Services*. Reimbursement for anesthesia related to electroconvulsive therapy (ECT) shall be the responsibility of the MCO.

K. **Vision services (MCO only):** The benefit package includes vision services, as detailed in 8.310.6 NMAC, *Vision Care Services*.

L. **Audiology services (MCO only):** The benefit package includes audiology services, as detailed in 8.324.6 NMAC, *Hearing Aids and Related Evaluation.*

M. **Dental services (MCO only):** The benefit package includes dental services, as detailed in 8.310.7 NMAC, *Dental Services*.

N. **Dialysis services (MCO only):** The benefit package includes medically necessary dialysis services, as detailed in 8.325.2 NMAC, *Dialysis Services*. Dialysis providers shall assist members in applying for and pursuing final medicare eligibility determination.

O. **Pharmacy services (MCO/SE):** The benefit package includes all pharmacy and related services, as detailed in 8.324.4 NMAC, *Pharmacy Services*. The MCO/SE shall maintain written policies and procedures governing its drug utilization review (DUR) program in compliance with all applicable federal medicaid laws. The MCO/SE shall use a single medicaid preferred drug list (PDL). The MCO/SE shall cover brand name drugs and drug items not generally on the MCO/SE formulary or PDL when determined to be medically necessary by the MCO/SE or through a fair hearing process. The 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 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 MCO shall coordinate as necessary with the SE, and the SE shall coordinate with the 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. The MCO/SE shall ensure that Native American members accessing the pharmacy benefit at IHS or Tribal 638 facilities will be exempt for the MCO's/SE's preferred drug list.

P. **Durable medical equipment and medical supplies (MCO only):** The benefit package includes the purchase, delivery, maintenance and repair of equipment, oxygen and oxygen administration equipment, nutritional products, disposable diapers, augmentative alternative communication devices and disposable supplies essential for the use of the equipment, as detailed in 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

Q. **EPSDT services (MCO/SE):** The benefit package includes the delivery of the federally mandated early and periodic screening, diagnostic and treatment (EPSDT) services provided by a PCP and physical or behavioral health specialist, as detailed in 8.320.2 NMAC, *EPSDT Services*. The SE shall provide access to early intervention programs/services for members identified in an EPSDT screen as being at risk for developing or having a severe emotional, behavioral or neurobiological disorder.

R. **Tot-to-teen health checks (MCO only):** The MCO shall adhere to the periodicity schedule and ensure that eligible members receive EPSDT screens (tot-to-teen health checks). The services include the following with respect to treatment follow-up:

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

(2) development of a proactive approach to ensure that the members receive the services;

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

(4) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(5) processes to document, measure and assure compliance with the periodicity schedule; and

(6) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for vision and hearing screening, dental examinations and current immunizations; the MCO will facilitate referral to the SE for identified behavioral health conditions.

S. **EPSDT private duty nursing (MCO only):** The benefit package includes private duty nursing for the EPSDT population, as detailed in 8.323.4 NMAC, *EPSDT Private Duty Nursing Services*. The services shall either be delivered in the member's home or the school setting.

T. **EPSDT personal care (MCO only):** The benefit package includes personal care services for the EPSDT population, as detailed in 8.323.2 NMAC, *EPSDT Personal Care Services*.

U. **Services provided in schools (MCO/SE):** The benefit package includes services provided in schools, excluding those 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*.

V. **Nutritional services (MCO only):** The benefit package includes nutritional services furnished to pregnant women and children as detailed in 8.324.9 NMAC, *Nutrition Services*.

W. **Home health services (MCO only):** The benefit package includes home health services, as detailed in 8.325.9 NMAC, *Home Health Services*. The MCO is required to coordinate home health and the home and community-based waiver programs if a member is eligible for both home health and waiver services.

X. **Hospice services (MCO only):** The benefit package includes hospice services, as detailed in 8.325.4 NMAC, *Hospice Care Services*.

Y. **Ambulatory surgical services (MCO only):** The benefit package includes surgical services rendered in an ambulatory surgical center setting, as detailed in 8.324.10 NMAC, *Ambulatory Surgical Center Services*.

Z. **Rehabilitation services (MCO only):** The benefit package includes inpatient and outpatient hospital and outpatient physical, occupational and speech therapy services, as detailed in 8.325.8 NMAC, *Rehabilitation Services Providers* and licensed speech and language pathology services furnished under the EPSDT program as detailed in 8.323.5 NMAC, *Licensed Speech and Language Pathologists*. The MCO is required to coordinate rehabilitation services with the home and community-based waiver programs if a member is eligible for rehabilitation and waiver services.

AA. **Reproductive health services (MCO only):** The benefit package includes reproductive health services, as detailed in 8.325.3 NMAC, *Reproductive Health Services*. The MCO will provide female members with direct access to women's health specialists within the network for covered care necessary to provide women's

routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.

(1) The MCO shall provide medicaid members with sufficient information to allow them to make informed choices including the following:

(a) types of family planning services available;

(b) a member's right to access these services in a timely and confidential manner; and

(c) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the MCO network.

(2) If members choose to receive family planning services from an out-of-network provider, they shall be encouraged to exchange medical information between the PCP and the out-of-network provider for better coordination of care.

BB. **Pregnancy termination procedures (MCO only):** The benefit package includes services for the termination of pregnancy as allowed by 42 CFR 441.200 et seq. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC.

CC. **Emergency and non-emergency transportation services (MCO only):** The benefit package includes transportation service such as ground ambulance, air ambulance, taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC, *Transportation Services*. Non-emergency transportation is covered only when a member does not have a source of transportation available and when the member does not have access to alternative free sources. The MCO/SE shall coordinate efforts when providing transportation services for medicaid members/customers requiring physical or behavioral health services.

DD. **Prosthetics and orthotics (MCO only):** The benefit package includes prosthetic and orthotic services as detailed in 8.324.8 NMAC, *Prosthetics and Orthotics*.

EE. **Preventative physical health services (MCO only):** The benefit package shall include preventative services that follow current national standards and are recommended by the U.S preventive services task force, the centers for disease control and prevention, or the American college of obstetricians and gynecologists. The MCO shall follow current national standards for preventive health services.

FF. **Telehealth Services (MCO/SE):** The benefit package includes telehealth services as detailed in 8.310.13 NMAC, *Telehealth Services.*

[8.305.7.11 NMAC - Rp 8.305.7.11 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 8 QUALITY MANAGEMENT

8.305.8.9 QUALITY MANAGEMENT: [~~HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems.~~] Quality management is both a philosophy and a method of management designed to improve the quality of services; includes both quality assurance and quality improvement activities; and, is incorporated into health care delivery and administrative systems.
[8.305.8.9 NMAC - Rp 8 NMAC 4.MAD.606.7, 7-1-01; A, 7-1-04; a, 7-1-09]

8.305.8.11 BROAD STANDARDS:

A. **NCQA requirement:** The MCO shall have and maintain national committee for quality assurance (NCQA) accreditation for its medicaid product line. If the MCO is not so accredited, it will actively pursue such accreditation. NCQA accreditation is not required for the SE.

(1) [~~An MCO with NCQA national accreditation shall provide HSD a copy of its current certificate of accreditation together with a copy of the survey report, scores for the medicaid product line using the standards categories and scores using the reporting categories. In addition, the MCO shall provide to HSD a copy of any annual NCQA or national accreditation review/revision of accreditation status for the medicaid product line.~~] An MCO with NCQA national accreditation shall provide HSD with a copy of its current certificate of accreditation, a copy of any accreditation review/revision of accreditation status and a copy of the NCQA survey report for the Medicaid product line.

(2) [~~If the MCO is not accredited, it~~] A non-accredited MCO must provide a copy of the NCQA/national accreditation confirmation letter indicating the date for the site visit.

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

C. **Mental health reporting requirement:** The SE shall [~~be responsible for the collection and submission of~~] collect and submit a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey for both the medicaid adult and child family population annually. [~~as an annual reporting requirement. The SE shall adhere to the established HSD survey administration and reporting process.~~] [~~The annual C/FSP shall also~~] The annual C/FSP survey shall be conducted on a calendar year basis and shall 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 for medicaid based on the aggregate survey data results for both the child/family and adult medicaid populations.

D. **Collection of clinical data:** [~~For indicators requiring clinical data as a data source, the~~] The MCO/SE 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~~] clinical data utilizing a sample of clinical records sufficient to produce statistically valid results. The sample shall support stratification of the population served.

E. **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.~~] For reporting purposes, BH data for medicaid managed care members shall include all behavioral health services regardless of setting or location. Data shall be collected and reported as required to HSD.

F. **Provision of emergency services:** The MCO shall ensure that acute general hospitals are

reimbursed for emergency services provided in compliance of federal mandates, [~~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. Section 1395dd. (1867 of the Social Security Act). The SE shall ensure that the UNM psychiatric emergency room is reimbursed for emergency services provided.

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

H. **Other required reporting:** The MCO/SE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et seq. and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et seq. [~~In addition to any and all remedies or penalties set forth in this agreement, any~~] Any violation of this provision shall be reported to the HHS and the appropriate regional office of the environmental protection agency.

[8.305.8.11 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** [~~Quality management is an integrated approach that links knowledge, structure and processes together throughout an MCO/SE's system to assess and improve quality. The goal of quality improvement activities is to improve the quality of clinical care and services provided to members in the areas of health care delivery as well as supportive administrative systems.~~] The MCO/SE's quality management (QM) and improvement (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 MCO/SE shall submit annually its comprehensive QM/QI plan for the coming year 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 MCO/SE shall be reviewed and approved by HSD annually.~~] Internal processes shall be transparent and accountable. The MCO/SE's [~~QI/QM~~] QM/QI activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review (EQR) annual evaluation, [~~opportunities for improvement identified from either the~~] annual HEDIS indicators, [~~or~~] state defined performance measures and [~~the annually required~~] consumer satisfaction surveys and provider surveys [~~as well as any findings identified by an accreditation body such as NCQA~~].

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

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

~~(3) The program description shall specify the roles, authority and responsibilities of a designated physician/psychiatrist in the 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 MCO/SE providers, committee member selection policies, roles and responsibilities.~~]

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

(2) Internal processes shall be transparent and accountable.

[~~(8)~~] (3) The program description shall address QI for all major demographic groups within the MCO/SE. [~~, such as, infants, children, adolescents, adults, seniors and special population groups, including, but not limited to, specific racial and ethnic groups, pregnant members, developmentally disabled members and persons with behavioral health disorders (SE only), including co-occurring disorders, or other chronic diseases.~~

~~(9) The program description shall address member satisfaction, including 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 providers of results.~~

~~(10)~~] (4) The QM/QI description or work plan shall address the process by which the MCO/SE adopts reviews, [~~at least every two years and appropriately~~] updates and disseminates evidence-based clinical practice

guidelines for provision of services for acute and chronic conditions, including behavioral health (SE only). The MCO/SE shall involve its providers in this process.

[~~(11) The program description or work plan shall address activities aimed at addressing culture-specific health beliefs and behaviors as well as risk conditions and shall respond to member and 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. The MCO/SE shall incorporate cultural competence into utilization management, quality improvement, and the planning for the course of treatment.~~

~~(12)~~] (5) The program description or work plan shall address activities to improve 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 providers about the programs and services for members assigned to them.

[~~(13) The program description or 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 or 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 shall include: objectives for the year; activities regarding quality of clinical care and service, timelines, responsible person, planned monitoring for both newly identified and previously identified issues and an annual evaluation of the QI program.~~

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

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

~~(18)~~] (6) The annual written evaluation [~~submitted to HSD~~] shall include a review of completed and continuing quality improvement 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 8.305.8.12 NMAC, *Effectiveness of the QI Program*)~~

~~(19) For targeting QI activities to the provider and consumer surveys, the program description or work plan shall include specific activities related to findings identified in the annual consumer and provider surveys as areas that indicate targeted QI interventions and monitoring.~~]

B. **Program operations:** The [~~QI~~] QM/QI committee shall:

(1) [~~recommend QI policy~~] review and evaluate the results of quality improvement activities, institute needed action and ensure follow-up, as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all [~~QI~~] QM/QI committee decisions and actions;

[~~(3) ensure that the MCO/SE's providers participate actively in the QI program;~~

~~(4)~~] (3) ensure that the MCO/SE shall coordinate the [~~QI~~] 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; and

[~~(5)~~] (4) ensure that [~~there shall be evidence that~~] the results of [~~QI~~] QM/QI activities, performance improvement projects and reviews are used to improve quality; [~~there will be evidence of communication of and use of the results of QI activities, performance improvement projects and reviews, with appropriate individual and institutional providers;~~

~~(6) ensure that the MCO/SE shall also coordinate 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 services, such as compliance with state standards;~~

~~(7) ensure that the MCO/SE QI program is applied to the entire range of health services provided through the MCO/SE by assuring that all major population groups, care 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 an MCO/SE's enrollment; and~~

~~(8) ensure that stakeholders/members have an opportunity to provide input.~~]

C. **Health services contracting:** Contracts with individual and institutional providers shall specify

[~~that contractors cooperate~~] compliance with the MCO/SE's [~~QI~~] QM/QI program.

D. **Continuous quality improvement/total quality management:** The MCO/SE shall ensure that both clinical and nonclinical aspects of the MCO/SE quality management program shall be 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) be data driven;

(3) use real-time member and provider input to develop CQI activities; and

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

E. **Member satisfaction:** The MCO/SE shall [~~implement methods aimed at member satisfaction with the active involvement and participation of members and their families, whenever possible~~] ensure results of member satisfaction surveys are used to improve quality.

[~~(1) The MCO in accordance with NCQA requirements, 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)~~] (1) The MCO/SE shall evaluate member grievances and appeals for trends and specific problems. [~~, including behavioral health problems~~.

~~(3)~~] (2) The MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement. [~~in the quality of MCO/SE performance.~~

~~(4)~~] (3) The MCO/SE shall implement interventions and measure the effectiveness of these interventions. [~~to improve its performance.~~

~~(5) The MCO/SE shall measure the effectiveness of the interventions.~~

~~(6)~~] (4) The MCO/SE shall inform members, providers [~~,~~] and HSD [~~, and the MCO/SE members~~] of the results of member satisfaction activities as specified by HSD.

[~~(7) The MCO shall participate in the design of specific questions for the CAHPS adult and child surveys.~~]

F. **Health management systems:**

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

(a) The 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,~~] conditions and offer appropriate outreach, services and programs to assist in managing and improving their chronic behavioral health [~~conditions~~] patient outcomes.

[~~(b) The SE shall proactively identify the unduplicated number of adult severely disabled mentally ill (SDMI) and severe 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 MCO/SE shall report the following adverse events involving SDMI, SED, CSA, and co-occurring mental health and substance abuse members to HSD on a monthly basis: suicides, other deaths, attempted suicides, involuntary hospitalizations, detentions for protective custody and detentions for alleged criminal activity utilizing and HSD-provided reporting template. The SE shall utilize HSD's definitions for the identification of these categories of behavioral health members for standardization purposes.~~

~~(d)~~] (b) The MCO/SE shall proactively identify individuals with special health care needs who have or are at increased risk for a chronic physical or behavioral health condition.

[~~(e)~~] (c) The MCO/SE shall inform and educate its providers about using the health management programs for the members.

(d) The MCO/SE shall facilitate, through their committee structure, a process for identifying and addressing the appropriate use of psychopharmacological medications and adverse drug reactions.

[~~(f) The MCO/SE shall participate with providers to reduce inappropriate use of psychopharmacological medications and adverse drug reactions.~~

~~(g) The MCO/SE shall periodically update its providers regarding best practices and on the~~

~~procedures for appropriate healthcare referral.~~]

(2) The MCO/SE shall pursue continuity of care for members.

[~~(a) The MCO/SE shall report changes in its provider network to HSD.~~

~~(b) The MCO/SE shall have a defined health 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)~~] (a) The MCO/SE shall have a defined process to ensure prompt member notification by its providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing and this will be documented in the medical record.

[~~(d)~~] (b) The MCO/SE shall 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.

(c) The MCO/SE shall develop a policy and procedure that addresses the promotion of member compliance with follow up appointments, consultation/referrals and diagnostic laboratory, imaging and other testing.

[~~(e) The MCO/SE shall ensure that all medically necessary referrals are arranged and coordinated by either the referring provider or by the MCO/SE's care coordination unit.~~

~~(f) The MCO/SE shall implement policies and procedures to ensure that continuity and coordination of care occur across practices, provider sites and between the MCO/SE. In particular, the MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies such as DOH, CYFD protective services and juvenile justice, corrections community reentry services, as well as, with the schools. In addition, the SE shall coordinate services with all applicable state agencies comprising the collaborative.~~

~~(g) The MCO/SE shall assist and monitor for continuity of care the transitions between providers in order to avoid abrupt changes in treatment plan and caregiver for members currently being served.~~

~~(3) At the request of a member or legal guardian, the MCO/SE shall provide information 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 MCO/SE shall disseminate 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 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 MCO/SE shall involve board certified providers from its network who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

(4) The 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 MCO/SE shall distribute the guidelines to the appropriate providers and, upon request, to HSD [~~, upon request~~].

[~~(6) The MCO/SE shall annually measure practitioner 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)~~] (6) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

[~~(8)~~] (7) The [~~MCOs~~] MCO/SE shall implement 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.~~]

H. **Quality assessment and performance improvement:** The MCO/SE shall achieve required minimum performance levels on performance measures, as established by HSD. [~~and by CMS, on certain quality performance measures and projects. These required levels of performance would address a broad spectrum of key aspects of enrollee care and services. These~~] The quality measures [~~may change from year to year and~~] may be used in part to determine the MCO assignment algorithm. [~~In addition, the MCO shall provide HSD with copies of all studies performed for national accreditation such as NCQA. The SE shall annually provide HSD with copies of its QM/QI studies including its data analysis.~~]

(1) [~~An agreed upon number of disease~~] Disease management/performance measures shall be identified [~~by HSD, in consultation with the MCO, at the beginning of each contract year. The MCO/SE shall achieve minimum performance levels set by HSD for each performance measure. Examples of quality measures used in performance improvement projects may include: EPSDT screening rates, childhood and adolescent immunization rates, ER visits or adherence to grievance resolution timeframes. The SE shall implement the required number of targeted disease management programs as defined by HSD such as depression, bipolar disorder and co-occurring disorders.~~] at the beginning of each contract year by HSD.

(2) The 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.

[~~I. **Intervention and follow-up for clinical and service issues:** The 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.~~

~~(1) The MCO/SE shall implement interventions to improve practitioner and system performance as appropriate.~~

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

~~(3) The MCO/SE shall implement appropriate corrective interventions when it identifies underutilization or overutilization.~~

[~~J.~~] I. **Effectiveness of the [~~QI~~] QM/QI program:** The MCO/SE shall evaluate the overall effectiveness of its [~~QI~~]QM/QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members. An annual written evaluation, submitted to HSD, shall include a description of completed and ongoing quality improvement activities; trending of measures; and, analysis of demonstrated improvement of identified opportunities for improvement.

[~~(1) The MCO/SE shall perform an annual written evaluation of the QI program and provide a copy to HSD 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 care, provided to members.~~]

[8.305.8.12 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: [~~New Mexico medicaid requires appropriate utilization management (UM) standards to be implemented as well as activities to be performed so that excellent services are provided in a coordinated fashion with neither over nor under utilization.~~] The MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria[~~, which are~~] congruent with HSD's medical necessity service definition. The MCO/SE shall request approval from HSD of all UM and level of care criteria. Utilization management (UM) standards shall be applied consistently so excellent services are provided in a coordinated fashion with neither over-nor under-utilization. [~~as defined in 8.305.1 NMAC and are applied consistently in UM decisions by the MCO/SE.~~] The MCO/SE's utilization management program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals [~~in order to manage the use of limited resources; to maximize the effectiveness of care by evaluating clinical appropriateness;~~] to authorize [~~the type and volume of~~] services through fair, consistent and [~~culturally~~] competent decision making [~~; and~~] to assure equitable access to care. These standards shall also apply to pharmacy utilization management including the formulary exception process. Services provided within the IHS and tribal 638 networks are not subject to prior authorization requirements, except for behavioral health residential treatment center (RTC) services.

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 MCO and entities to which the MCO/SE delegates UM activities.

(2) A designated physician and a behavioral health care physician for the SE 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 care coordination, discharge criteria, [~~site of services,~~] levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services; and 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 medicaid as set forth in 42 CFR Section 440.230.~~

~~(4) The MCO/SE shall ensure that the services are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished. The 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)~~] (4) The UM program shall be evaluated and approved annually by senior management and the medical (or behavioral health) director or the QI committee.

[~~(6)~~] (5) The UM program shall include policies and procedures for monitoring inter-rater reliability of all individuals performing UR review. The procedures shall include a monitoring and education process for all UR staff identified as not meeting 90% agreement on test cases, until adequately resolved.

B. **UM decision criteria:** [~~To make utilization decisions, the~~] The 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.~~] The MCO/SE shall ensure that the services are no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230. The 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.

(2) The criteria for determining medical necessity shall be academically defensible[~~; based on national standards of practice when such standards are available; involve appropriate practitioners when developing, adopting and reviewing criteria; and acceptable to the MCO/SE's medical (or behavioral health) director, peer consultants and relevant local providers~~]. The 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~~] The 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 MCO/SE shall maintain evidence that [~~it has reviewed~~] the criteria has been reviewed and updated at specified intervals [~~and that the criteria have been updated, as necessary~~].

(5) The MCO/SE shall state in writing how practitioners can obtain UM criteria and shall provide criteria to its practitioners upon request. The MCO/SE shall have written policies and procedures describing how health professionals may access the clinical information used to support UM decisions.

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

(1) have a policy and procedure in place for authorization requests and decisions;

(2) require [~~that its~~] subcontractors have [~~in place~~]written policies and procedures for authorization requests and decisions;

(3) [~~have in effect a mechanism to~~]ensure consistent application of review criteria for authorization decisions; and

(4) consult with requesting providers when appropriate.

D. **Use of qualified professionals:** The MCO/SE shall [~~have written policies and procedures explaining how qualified health professionals shall assess the clinical information used to support UM decisions .~~] utilize appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews and are qualified to supervise review decisions.

[~~(1) Appropriately licensed and experienced health care practitioners 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 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 practitioner responsible for justifying the medical necessity.~~]

E. **Timeliness of decisions and notifications:** The MCO/SE shall make utilization decisions and notifications in a timely manner that accommodates the clinical urgency of the situation and shall minimize disruption in the provision and continuity of health care services. The following time frames are required and shall not be affected by "pend" decisions.

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) care, the 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) care, the MCO/SE shall notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) care, the MCO/SE shall give the member and 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 care, the MCO/SE shall make a decision and notify the provider of the decision within 72 hours of receipt of request. For authorization of urgent care that results in a denial, the MCO/SE shall notify both the member and provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent care, the MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision. The 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 working days from receipt of request for service.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent care, a 14 calendar day extension may be requested by the member or provider. A 14 calendar day extension may also be requested by the MCO/SE. The 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 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 MCO/SE shall notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The 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 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 MCO/SE shall notify a provider of the decision within one working day of making the decision. The MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The 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 MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to provider noncompliance with the MCO/SE's

administrative policies, the 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 MCO/SE shall obtain relevant clinical information and consult with the treating practitioner, 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 MCO/SE UM policies and procedures will clearly define in writing for providers what constitutes relevant clinical information.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating providers.

G. **Denial of services:** A "denial" is a [~~nonauthorization~~] non-authorization of a request for care or services. The MCO/SE shall clearly document in the UR file a reference to the provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

(1) The 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 MCO/SE medical director.

(2) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the MCO/SE shall deny that which was determined to be inappropriate, and recommend an appropriate alternative level of care (setting).

(3) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner.

(4) The MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.

[~~(2)~~] (5) The MCO/SE shall make available to a requesting provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

[~~(3) The MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.~~

~~(4)~~] (6) The 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 MCO/SE, unless the MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each MCO/SE contract must provide that, consistent with 42 CFR Sections 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 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 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 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) An 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 MCO/SE shall evaluate member and provider satisfaction with the UM process based on member and provider satisfaction survey results. The MCO/SE shall forward the

evaluation results to HSD.

K. **HSD access:** HSD shall have access to the MCO/SE's UM review documentation on request.
[8.305.8.13 NMAC - Rp 8 NMAC 4.MAD.606.7.4, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The MCO/SE shall document the mechanism for credentialing and recredentialing of 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~~] The documentation shall include, but not be limited to, defining the scope of 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~~] 45 days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCOs shall all use the same primary source verification entity unless there are more cost effective alternatives approved by HSD.

A. **Practitioner participation:** The MCO/SE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Primary source verification:** [~~At the time of credentialing the provider, the~~] The MCO/SE shall verify the following information from primary sources during credentialing:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner 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 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 practitioner;

(5) board certification if the practitioner states on the application that the practitioner is board certified in a specialty; [~~and~~]

(6) current, adequate malpractice insurance, according to the MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The MCO/SE shall use the HSD-approved credentialing form. The 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 practitioner is credentialed, the MCO/SE shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner 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 practitioner types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the practitioner's discipline[~~;~~] .

(3) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance plan (SCHIP), and all federal health care programs (as defined in section 1128B(f) of the Social Security Act; sanctions by medicare, [~~and medicaid , as applicable.~~] medicaid, the state children's health insurance program or any federal care program.

E. **Evaluation of practitioner site and medical records.** [~~At the time of credentialing the~~] The MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists[~~. The~~] and the SE shall perform an initial visit to the offices of potential high volume behavioral health care practitioners, prior to acceptance and inclusion as participating providers. The MCO/SE shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO/SE shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the managed care contract.

(2) The MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO/SE's organizational standards.

F. **Recredentialing:** The MCO/SE shall have formalized recredentialing procedures.

(1) The MCO/SE shall [~~formally~~] recredential its providers at least every three years. [~~During the recredentialing process the~~] The MCO/SE shall verify the following information from primary sources during recredentialing:

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the practitioner 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 practitioner; 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 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 practitioner types; [~~and~~]

(i) other recognized monitoring organizations appropriate to the practitioner's discipline [~~.~~] ; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance program and all federal health care programs.

(3) The MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E of 8.305.8.14 NMAC.

G. **Imposition of remedies:** The MCO/SE shall have policies and procedures for altering the conditions of the practitioner's participation with the MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the MCO/SE may take to improve the provider's performance prior to termination.

(1) The MCO/SE shall have procedures for reporting to appropriate authorities, including HSD, serious quality deficiencies that could result in a practitioner's suspension or termination.

(2) The MCO/SE shall have an appeal process by which the MCO/SE may change the conditions of a practitioner's participation based on issues of quality of care and service. The MCO/SE shall inform providers of the appeal process in writing.

H. **Assessment of organizational providers:** The 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. [~~Providers include, but are not limited to, hospitals, home health agencies, nursing 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 MCO/SE shall: [~~confirm that the 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 MCO/SE.~~]

(1) [~~The MCO/SE shall~~] confirm that the 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 MCO/SE shall~~] confirm that the 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.

[8.305.8.14 NMAC - Rp 8 NMAC 4.MAD.606.7.5, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.15 MEMBER BILL OF RIGHTS: [~~Under medicaid managed care, members have certain rights and responsibilities and the~~] The MCO/SE shall have policies and procedures governing member rights and responsibilities and require adherence by all providers, including MCO-contracted providers. 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 health care providers in decision making in all aspects of their health care, 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 care decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the MCO/SE network, or the 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 provider is not authorizing requested care.

(8) Members or their legal guardians shall have a right to voice grievances about the care provided by the MCO/SE and to make use of the 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 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 care 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 MCO/SE, its health care services, how to access those services, and the MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the MCO/SE or its network providers in regard to contractual disputes between the 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) (MCO only) Members or their legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.

B. **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 MCO/SE and 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 care that they have agreed upon with their providers or to notify 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.

C. **MCO/SE responsibilities:**

(1) The MCO/SE shall provide a member handbook to its members and to potential members who request the handbook and have the handbook accessible via the internet. The MCO/SE shall publish [~~in the member handbook~~] the members' rights and responsibilities from the member bill of rights in the member handbook. MCOs/SE shall honor the provisions set forth in the member bill of rights.

(2) The MCO/SE shall comply with the grievance resolutions process [~~found~~] delineated in 8.305.12 NMAC, *MCO Member Grievance System*.

(3) The MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the 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 enrollees understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the 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 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 MCO/SE shall protect the confidentiality of member information and records.

(a) The MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The MCO/SE's contracts with providers shall explicitly state expectations about confidentiality of member information and records.

(c) The MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the MCO/SE of identifiable personal information to a person or agency outside the 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 MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The 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 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 MCO/SE delegates member service activity, the MCO/SE shall retain responsibility for documenting MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to providers within the MCO/SE network. The MCO/SE shall have written policies regarding the requirement for 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 MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The MCO/SE shall ensure that its providers and their facilities comply with the Americans with Disabilities Act.

[~~(10) The 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)~~] (10) The 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)~~] (11) The MCO shall not restrict a member's right to choose a provider of family planning services.

[~~(13)~~] (12) The 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 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 MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.305.8.15 NMAC - Rp 8 NMAC 4.MAD.606.7.6, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The MCO shall follow current national standards for preventive health services including behavioral health preventive services. [~~These standards~~] 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 MCO under these standards shall be adopted [~~,~~] and reviewed at least every two years, updated when appropriate and disseminated to practitioner and member. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The 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 care.

A. **Initial assessment:** The MCO shall perform an initial assessment of the medicaid member's health care needs within 90 days of the date the member enrolls in the MCO. For this purpose, a member is considered enrolled at the lock-in date. This assessment must include a question regarding the member's primary language spoken or written.

B. **Immunizations:** The 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 MCO shall provide the immunizations or verify the member's immunization history by a method acceptable to the health advisory committee.~~] The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico SIIS system.

C. **Screens:** The 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 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. Children shall receive BMI percentile designation.

(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 contraception, 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 9 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 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 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 MCO shall encourage PCPs to assess and document for age, height and gender appropriate weight and for BMI percentage 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 MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The 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 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 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 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 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 care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care 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.

[8.305.8.16 NMAC - Rp 8 NMAC 4.MAD.606.7.7, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07]

8.305.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The 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 care and quality review.

(1) The MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The MCO/SE shall have medical record documentation standards that are enforced with its 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) 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, 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 care, 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:~~] For behavioral health patients, documentation shall include all elements listed above in addition to the following:

(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 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 care.

B. **Review of records:** The MCO/SE shall have a process to systematically review provider medical records to ensure compliance with the medical record standards. The MCO/SE shall institute improvement and actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the MCO's primary care providers, obstetricians, and gynecologists. The EQRO shall conduct a review of a representative sample of clinical records from the SE's behavioral health providers to determine compliance with the SE's established medical record standards and goals.

(2) The MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site [~~follow-up plans to increase~~] compliance with the MCO/SE's established medical record standards and goals.

C. **Access to records:** The MCO/SE shall provide HSD or its designee appropriate access to provider medical records.

(1) The MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The MCO shall ensure that providers involved in the member's care have access to the member's primary medical record including the SE, when necessary.

(2) The MCO/SE shall include provisions in its contracts with providers for appropriate access to the 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 physical health and behavioral health care providers[~~, including behavioral health, for each clinical encounter~~].

(3) The MCO shall have a policy that ensures the confidential transfer of medical and dental

information[~~to another primary medical, or dental practitioner whenever~~] when a primary medical or dental provider leaves the MCO the member changes primary medical or dental practitioner or after a member changes enrollment from one MCO [~~and enrolls in~~] to another MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another [~~whenever~~] when 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 SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.

[~~(5)~~] (6) The MCO/SE shall forward [~~to HSD or it designee, specific~~] health information from the provider's medical records to HSD or its designee, as requested. [~~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.~~]

[8.305.8.17 NMAC - Rp 8 NMAC 4.MAD.606.7.8, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service. [~~The MCO/SE shall submit documentation to HSD 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 MCO/SE shall provide access to the full array of covered services within the benefit package[~~. If~~] ; 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 care shall be covered by the 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 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 care 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 MCO/SE shall ensure that there is no clinically significant delay caused by the MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The 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 MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO/SE.

(3) The 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 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 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.

(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% of urban residents shall travel no farther than 30 miles;

(b) 90% of rural residents shall travel no farther than 45 miles; and

(c) 90% of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The MCO shall ensure that a sufficient number of pharmacy providers are available to members. The MCO 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% of urban residents shall travel no farther than 30 miles;

(2) 90% of rural residents shall travel no farther than 45 miles; and

(3) 90% of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The 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 MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members. The SE shall report to HSD all individual providers, provider groups, provider agencies or facilities and corresponding sites in its network that are not accepting new medicaid members.

(2) (MCO only) For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) (MCO only) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) (MCO only) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) (SE only) For nonurgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) (MCO/SE) Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

(7) (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) (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) (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) (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) (MCO/SE) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

(12) (MCO/SE) The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

(13) The MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.305.7.11 NMAC, *Services Included in the Salud! Benefit Package, Pharmacy Services*.

(15) The 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 MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The 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 MCO lists of needed supplies monthly; and the 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 MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.

F. **Access to transportation services:** The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall coordinate behavioral health transportation services with the SE[~~, and the SE shall coordinate transportation services with the member's respective MCO~~]. The MCO shall have sufficient transportation 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 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 MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.305.8.18 NMAC - Rp 8 NMAC 4.MAD.606.7.9, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.19 DELEGATION: Delegation is a process whereby an MCO/SE gives another entity the authority to perform certain functions on its behalf. The MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The 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 with the written approval of the MCO~~].

A. A mutually agreed upon document between MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the MCO/SE;

(4) the process by which the MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the MCO/SE if the delegated entity does not fulfill its obligations.

B. The MCO/SE shall document evidence that the 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 MCO/SE's

expectations and HSD's standards.
[8.305.8.19 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 9 COORDINATION OF SERVICES

8.305.9.9 COORDINATION OF SERVICES:

A. The MCO/SE shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.305.15.9 NMAC. Care coordination is defined as [~~a service to assist members with special health care needs, on an as needed basis.~~] an office-based administrative function to assist members at risk for adverse outcomes to help meet their needs by filling the gaps in current health care on an as needed basis. Care coordination is member-centered, consumer-directed and family-focused, culturally competent, strengths-based and ensures that medical and behavioral health needs are identified. Services are provided and coordinated with the member and family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; monitoring outcomes and resource use; coordinating visits with subspecialists; organizing care to avoid duplication of diagnostic tests and services; sharing information among health care professionals and family; facilitating access to services; actively managing transition of care such as hospital discharge; training caregivers; and ongoing reassessment and refinement of the care plan. [~~It is member-centered, family-focused when appropriate, culturally competent and strength-based.~~] Care coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and services are provided and coordinated with all service providers, individual members and family, if appropriate, and authorized by the member. Care coordination operates within the MCO/SE with a dedicated care coordination staff functioning independently, but is structurally linked to the other MCO/SE systems, such as quality assurance, member services and grievances. Care coordination is not "gate keeping" or "utilization management". Clinical decisions shall be based on the 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. The MCO/SE responsible for the care of the most acute condition shall be primary lead on care coordination activities with necessary assistance and collaboration from both entities. Care shall be coordinated between both physical health MCO staff and behavioral health SE staff. The MCO/SE shall conduct the following system processes for care 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 care coordination for all medicaid eligible ISHCN, as required by federal regulations.

B. The care coordinator shall be responsible for the following activities:

(1) communicate to the member the care coordinator's name and how to contact this person;

(2) ensure and coordinate access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) ensure appropriate coordination between physical and behavioral health services and non-managed care services; and, in the case of the SE, also coordinate care among other applicable agencies in the collaborative;

(4) coordinate the needs and identify the status of co-managed cases with either the MCO physical health care coordinator or the SE behavioral health care coordinator;

(5) monitor 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) (MCO ONLY) ensure the development of a member's individual plan of care, 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 care and ensures revision of the plan as needed;

(9) involve the member and family in the development of the plan of care, as appropriate; a member or family shall have the right to refuse care coordination or case management, that will be documented in the care coordination file; and

(10) ensure that all necessary information is shared with key providers [~~with the member's written permission or documented verbal permission~~] to ensure optimum care; the MCO/SE shall ensure and document that the releasing provider has obtained either written or documented verbal permission from the member for the release of information; this information sharing is required [~~to ensure optimum care and~~] communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems.

C. For clarification purposes, activities provided through care coordination at the 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

[8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.10 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 MCO and SE. The MCO and SE shall coordinate a member's care with one another, if the member has both physical and behavioral health needs. Both physical and behavioral health care 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 MCO and the SE shall develop and share policies and procedures to ensure effective care coordination across systems as authorized by the member. Both contractors shall be responsible for monitoring the effectiveness of referrals and coordinating with multiple providers and for the process of information sharing between the physical and behavioral health care providers. The 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 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 MCO/SE shall implement policies and procedures that maximize care 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 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 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 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 referrals for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the member's written consent.

E. **Referral policies and procedures:** The MCO/SE shall offer statewide trainings to all providers regarding its specific referral policies and procedures. [~~The MCO/SE referral policies and procedures shall also be provided in provider manuals distributed to all contracted providers.~~] The 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. These referral policies and procedures shall be provided in provider manuals distributed to all contracted providers. 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 screening and evaluation.

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 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 MCO as authorized by the member. The MCO shall educate and assist the physical health providers to make appropriate referrals for behavioral health consultation and treatment.

H. **Independent access:** The MCO/SE shall develop and implement policies and procedures that allow members 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 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 care for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) 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.

(2) The 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.

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.
[8.305.9.10 NMAC - Rp 8.305.9.10 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.11 COORDINATION WITH WAIVER PROGRAMS: The MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex care coordination. The MCO/SE shall coordinate care with the member's waiver case manager or the mi via consultant to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD shall monitor utilization of services by waiver recipients to ensure that the MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.
[8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 10 ENCOUNTERS

8.305.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The MCOs/SE shall submit encounter data to HSD within 120 days of the service delivery date, payment date or discharge as defined by HSD. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.305.10.11 NMAC - Rp 8 NMAC 4.MAD.606.9.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 COORDINATED LONG-TERM SERVICES
PART 11 REIMBURSEMENT FOR MANAGED CARE

8.305.11.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services:** HSD shall make actuarially sound payments under capitated risk contracts to the designated MCO/SE. Rates, whether set by HSD, or negotiated between HSD and the 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 MCO/SE shall be responsible for the provision of services for members during the month of capitation. Medicaid members shall not be liable for debts incurred by an MCO/SE under the MCO's or SE's managed care contract for providing health care to medicaid members. This shall include, but not be limited to:

(1) the MCO's/SE's debts in the event of the MCO's/SE's insolvency;

(2) services provided to the member, that are not included in the medicaid benefit package and for which HSD does not pay the MCO/SE, e.g., value added services;

(3) when the MCO/SE does not pay the health care 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 MCO/SE provided the service directly; and

(5) if an MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the 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 MCO/SE for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The 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/MAD will calculate or verify the MCO/SE's income at the end of the state fiscal year to determine if the extent was expended 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 MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the 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 time frames:** Clean claims as defined in Subsection L of 8.305.1.7 NMAC, *Clean Claim*, shall be paid by the MCO/SE to contracted and noncontracted providers according to the following timeframe: 90% within 30 days of the date of receipt and 99 percent within 90 days of the date of receipt, as required by federal guidelines in the Code of Federal Regulations, Section 42 CFR 447.45. The date of receipt is the date the MCO/SE first receives the claim either manually or electronically. The 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 MCO/SE and its 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 MCO/SE. The MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) An MCO/SE shall pay contracted and noncontracted providers interest on the MCO's/SE's liability at the rate of 1 1/2 percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating 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 MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

(2) No contract between the MCO/SE and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO/SE is unable to determine liability for, or refuses to pay, a claim of a participating provider within the times specified above, the MCO/SE shall make a good-faith effort to notify the participating

provider by fax, electronic or other written communication within 30 days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

D. **Rate setting:** Capitation rates paid by HSD to the MCO/SE for the provision of the managed care medicaid 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 risk basis:** The MCO/SE is at risk of incurring losses if its costs of providing the managed care medicaid benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO/SE to reflect the actual cost of services furnished by the 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; CMS requiring a modification of the state's waiver; if 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:** An MCO/SE that contracts with HSD to provide medicaid physical or behavioral 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 MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the MCO's/SE's financial condition. Requests for information and records shall be delivered to HSD, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** An MCO participating in medicaid managed care shall purchase reinsurance at a minimum of $1,000,000.00 in reinsurance protection against financial loss due to outlier (catastrophic) cases. The MCO shall document for HSD 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, or other risk sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The MCO/SE shall be responsible for identifying a member's third party coverage and coordinating of benefits with third parties as required by federal law. The MCO/SE shall inform HSD when a member has other health care insurance coverage. The MCO shall have the sole right of subrogration, for 12 months, from when the MCO incurred the cost on behalf of the members, 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 (TPL) for members available to HSD/MAD for audit and review. If the 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 MCO/SE shall provide to HSD for audit and review all records pertaining to TPL collections for members.

(3) **Fidelity bond requirement:** The MCO/SE shall maintain a fidelity bond in the maximum amount specified under the Insurance Code.

(4) **Net worth requirement:** The MCO/SE shall comply with the net worth requirements of the Insurance Code.

(5) **Solvency cash reserve requirement:** The 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 MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. [~~If the agreement replaces a previous agreement with HSD/MAD to provide Medicaid managed care, then continued maintenance of the per member cash reserve established and maintained by the MCO/SE pursuant to such previous agreement shall be deemed to satisfy this requirement.~~] HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of the MCO's/SE's members, or the failure of the MCO/SE to maintain the required cash reserve, and shall notify the MCO/SE of the cash reserve requirement. Each MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment for services to the MCO's/SE's members in the event that the MCO/SE becomes insolvent. Money in the reserve account remains the property of the MCO/SE, and any interest earned (even if retained in the account) shall be the property of the MCO/SE. Failure to maintain the reserve as directed above will result in financial penalties equal to the amount of shortfall in the account each month. If the cash reserve account exceeds 105% of an amount equal to 3% of the annualized capitation as determined above, for more than two months, HSD will direct the MCO/SE to reduce the reserve to the 100% level and the MCO/SE shall comply with such direction within 30 days.

H. **Inspection and audit for solvency requirements:** The MCO/SE shall meet all requirements for state licensure with respect to inspection and auditing of financial records. The MCO/SE shall provide to HSD or its designee all financial records required by HSD. HSD, or its designees may inspect and audit the MCO's/SE's financial records at least annually or at HSD discretion.

I. **Special payment requirements:** This section lists special payment requirements by provider type.

(1) **Reimbursement for FQHCs:** Under federal law, FQHCs shall be reimbursed at 100 percent of reasonable cost under a medicaid fee-for-service or managed care program. The FQHC may waive its right to 100 percent of reasonable cost and elect to receive a rate negotiated with the MCO/SE. HSD shall provide a discounted wrap-around payment to FQHCs that have waived a right to 100 percent reimbursement of reasonable cost from the MCO/SE.

(2) **Reimbursement for providers furnishing care to Native Americans:** If an Indian health service (IHS) or tribal 638 provider delivers services to an MCO/SE member who is Native American, the MCO/SE shall reimburse the provider at the rate established by the office of management and budget (OMB) for specified services for the [~~IHS facilities, except when otherwise specified by HSD~~] IHS and Tribal 638 facilities and providers. Pharmacy, inpatient physician services, case management, vision appliances, nutritional services and ambulatory surgical center services shall be paid at the fee schedule rate established by HSD. With the exception of residential treatment center services, services provided at Indian health service and Tribal 638 facilities are not subject to prior authorization.

(3) **Reimbursement for family planning services:** The MCOs shall reimburse out-of-network family planning providers for services provided to MCO members at a rate at least equal to the medicaid fee-for-service 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 managed care has an established relationship with an obstetrical provider and desires to continue that relationship and the provider is not contracted with the MCO, the MCO shall reimburse the out-of-network provider for care 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 MCO/SE or FFS exempt, which was originally responsible for the hospital inpatient 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.~~] Regarding Salud! MCO and medicaid fee-for-service (FFS) members: If an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud! Regarding Salud! MCO and CoLTS MCO members: For members transitioning to CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.

(6) **Sanctions for noncompliance:** The department may impose financial penalties or sanctions against an MCO/SE that fails to meet the financial requirements specified in this section or additional requirements specified in the terms of the medicaid managed care contract or federal medicaid law.

J. **Recoupment payments:** HSD shall recoup payments for MCO members who are incorrectly enrolled with more than one MCO, including members categorized as newborns or X5; payments made for MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the 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 MCO/SE or HSD shall be recouped upon identification. In the event of an error, which causes payment(s) to the 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 the recoupment procedures shall be discussed in advance by HSD and the MCO/SE and documented in writing, prior to implementation of the

new automated recoupment process. The MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at 9 percent per annum on any capitation payment due to the 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 alternate payment methodology for specified program services or responsibilities.

[8.305.11.9 NMAC - Rp 8 NMAC 4.MAD.606.10, 7-1-01; A, 7-1-04; A, 71/05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-16-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 12 MCO MEMBER GRIEVANCE SYSTEM

8.305.12.10 GENERAL REQUIREMENTS FOR GRIEVANCE AND APPEALS:

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

B. The MCO/SE shall implement written policies and procedures describing how the member may submit a request for a grievance or an appeal with the MCO/SE or submit a request for a fair hearing with HSD. The policy shall include a description of how the MCO/SE resolves the grievance or appeal.

C. The MCO/SE shall provide to all service providers in the MCO/SE's network a written description of the MCO/SE's grievance and appeal process and how the provider can submit a grievance or appeal.

D. The MCO/SE shall have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

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

F. The 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 MCO/SE shall also ensure that health care professionals with appropriate clinical expertise shall make decisions for the following:

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

G. Upon enrollment, the 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 hearings bureau, upon notification of an MCO/SE action, or concurrent with, subsequent to or in lieu of an appeal of the MCO/SE action. The information shall meet the standards specified in Paragraph (15) of Subsection C of 8.305.8.15 NMAC.

H. The MCO/SE shall ensure that punitive or retaliatory action is not taken against a member or a provider that files a grievance or an appeal, or a provider that supports a member's grievance or appeal.

[8.305.12.10 NMAC - Rp 8.305.12.10 & 11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.12.12 APPEALS: An appeal is a request for review by the MCO/SE of an 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 MCO/SE to provide services in a timely manner, as defined by HSD; or
(5) the failure of the MCO/SE to complete the authorization request in a timely manner as defined in 42 CFR 438.408.

B. **Notice of MCO/SE action:** The MCO/SE shall mail a notice of action to the member or 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 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 MCO/SE has taken or intends to take;
(2) the reasons for the action;
(3) the member's or the provider's right, as applicable, to file an appeal of the MCO/SE action through the 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 an MCO/SE action within 90 calendar days of receiving the MCO/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 MCO/SE, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative, or estate representative of a deceased member as parties to the appeal.

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

E. The 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 within 10 calendar days that is signed by the member. The 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 MCO/SE shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO/SE shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO/SE may extend the 30-day timeframe by 14 calendar days if the member requests the extension, or the 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 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 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 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 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 MCO/SE shall provide written notice within the 30-calendar-day timeframe for resolutions to the member or the 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 MCO/SE's action.

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

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

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

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

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

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

(e) the member requests extension of the benefits.

(2) The MCO/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 MCO/SE's action is upheld, the 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 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 MCO/SE shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the 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 MCO/SE shall pay for these services.

[8.305.12.12 NMAC - Rp 8.305.12.12 NMAC, 7-1-04; A. 7-1-05; A, 9-1-06; A, 7-1-07, A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 13 FRAUD AND ABUSE

8.305.13.10 MANAGED CARE ORGANIZATION AND SINGLE STATEWIDE ENTITY REQUIREMENTS: The 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 providers and members. The MCO/SE 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. The MCO/SE shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The 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 prevention and detection of potential cases of fraud and abuse, such as claims edits, post processing review of claims, provider profiling/exception reporting and credentialing prior authorizations, utilization/quality management monitoring;

C. have a mechanism to work with HSD, or its designee, to further develop prevention and detection methods and best practices and to monitor outcomes for medicaid managed care;

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 the names of all providers identified with aberrant utilization, according to provider profiles, regardless of the cause of the aberrancy;

F. report to HSD any administrative action taken to limit the ability of an individual or entity to participate in the program;

G. report to HSD any individual or entity that has been excluded from providing items or services to medicaid members;

[~~F.~~] H. designate a compliance officer and a compliance committee who are accountable to senior management;

[~~G.~~] I. provide effective fraud and abuse detection training, administrative remedies for false claims and statements and whistleblower protection under such laws to the MCO/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) include as part of such written policies, detailed provision regarding the MCO/SE's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) include 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.~~] J. implement effective lines of communication between the compliance officer and the MCO/SE's employees;

[~~I.~~] K. require enforcement of standards through well-publicized disciplinary guidelines; and

[~~J.~~] L. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO/SE's contract.

[8.305.13.10 NMAC - Rp 8 NMAC 4.MAD.606.12.1, 7-1-01; A, 7-1-05; A, 7-1-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 14 REPORTING REQUIRMENTS

8.305.14.10 REPORTING STANDARDS:

A. Reports submitted by the MCO/SE to HSD shall meet certain standards.

(1) The MCO/SE shall verify the accuracy of data and other information on reports submitted. The MCO/SE shall send a written data certification. The data shall be certified by the MCO/SE's: 1) Chief Executive Officer; 2) Chief Financial Officer; or 3) an individual who has delegated authority to sign for, and who reports directly to, the MCO/SE's Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information and beliefs as to the accuracy, completeness and truthfulness of the documents and data. The MCO/SE shall submit the certification concurrently with the certified data and documents.

(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 MCO/SE shall analyze all required reports internally before submitting them to HSD. The MCO/SE shall analyze the report for any early patterns of change, identified trend, or outlier (catastrophic case), and shall submit this analysis with the required report. The MCO/SE shall send a written narrative for specified reports with the report documenting the MCO/SE's interpretation of the early pattern of change, identified trend, or outlier.

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 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 MCO/SE shall comply with changes specified by HSD.

[8.305.14.10 NMAC - Rp 8 NMAC 4.MAD.606.13.1, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 15 SERVICES FOR INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS

8.305.15.9 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 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 MCO/SE shall have written policies and procedures in place with HSD's approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify ISHCNs. The MCO/SE shall employ reasonable effort to identify ISHCNs based at least on the following criteria:

(1) individuals eligible for 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~~] individuals referred by family or a public or community program.

[8.305.15.9 NMAC - Rp 8.305.15.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.15.11 CHOICE OF SPECIALIST AS PCP: The 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.~~] provide all mandated PCP services. See 8.305.6.12 NMAC, *Primary Care Providers.*

[8.305.15.11 NMAC - Rp 8.305.15.11 NMAC, 7-1-04; A, 7-1-09]

8.305.15.14 CARE COORDINATION FOR ISHCN: The [~~MCOs~~] MCO/SE shall develop policies and procedures to provide care coordination for ISHCN. Please refer to Section 8.305.9.9 NMAC, *Coordination of Services*, for definition.

A. The MCO/SE shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential ISHCN. The contractor shall provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The 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 care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The MCO/SE shall have written policies and procedures for educating ISHCN [~~needs~~] and, in the case of children with special health care needs, parent(s), legal guardians, that care coordination is available and when it may be appropriate to their needs.

[8.305.15.14 NMAC - Rp 8.305.15.14 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.15.15 EMERGENCY, INPATIENT AND OUTPATIENT AMBULATORY SURGERY HOSPITAL REQUIREMENTS FOR ISHCN: The MCO/SE shall develop and implement policies and procedures for:

A. educating the ISHCN, the ISHCN's family members and/or caregivers concerning [~~the ISHCNs~~] ISHCN with complicated clinical histories on how to access emergency room care and what clinical history to provide when emergency care or inpatient admission is needed, including behavioral health emergency care;

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 and/or behavioral health clinical history; and

D. obtaining any necessary referrals from PCPs for inpatient hospital staff providing outpatient or ambulatory surgical procedures.

[8.305.15.15 NMAC - Rp 8.305.15.15 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 16 CLIENT TRANSITION OF CARE

8.305.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of members from one health care practitioner or setting to another as their condition and care needs change. The MCO/SE shall have the resources and policies and procedures in place to [~~ensure continuity of care without disruption in service to members and to assure the service provider of payment. The MCO/SE shall actively assist members, in particular ISHCN~~] actively assist members with transition of care. Members transitioning from institutional levels of care such as hospitals, nursing homes, residential treatment facilities or ICF/MRs back to community services with transition of care needs shall be [~~offered~~] provided with care coordination services [~~as indicated~~]. Medicaid-eligible clients may initially receive physical and behavioral health services under fee-for-service medicaid prior to enrollment in managed care. During the member's medicaid eligibility period, enrollment status with a particular MCO may change and the member may switch enrollment to a different MCO. Certain members covered under managed care may become exempt and other members may lose their medicaid eligibility while enrolled in an MCO/SE. A member changing from MCO to MCO, fee-for-service to managed care coverage and vice versa shall continue to receive medically necessary services in an uninterrupted manner.

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

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

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member and provider education about the MCO, about self-care and the optimization of treatment, and the review and update of existing courses of treatment. The SE shall be notified and coordination of care shall occur.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment. The MCO shall have written policies and procedures to facilitate a smooth transition of a member to another MCO when a member chooses and is approved to switch to another MCO.

(4) The MCO/SE shall have policies and procedures regarding provider responsibility for discharge planning upon the member's discharge from an inpatient or residential treatment facility, and the MCO/SE shall help coordinate for a seamless transition of post-discharge care. The MCO/SE shall have a mechanism for monitoring the transition of care from an inpatient or residential treatment facility.

B. **Prior authorization and provider payment requirements:**

(1) For newly enrolled members, the MCO/SE shall honor all prior authorizations granted by HSD through its contractors or the [~~CLTS~~] CoLTS MCO for the first 30 days of enrollment or until the MCO/SE has made other arrangements for the transition of services. Providers who delivered services approved by HSD through its contractors shall be reimbursed by the MCO/SE.

(2) For members who recently became exempt from managed care or enrolled in [~~CLTS~~] CoLTS, HSD or the [~~CLTS~~] CoLTS MCO shall honor prior authorization of fee-for-service covered benefits granted by the MCO/SE for the first 30 days under fee-for-service medicaid or until other arrangements for the transition of services have been made. Providers who deliver these services and are eligible and willing to enroll as medicaid fee-for-service providers shall be reimbursed by HSD.

(3) For members who had transplant services approved by HSD under fee-for-service or under [~~CLTS~~] CoLTS, the MCO shall reimburse the providers approved by HSD or [~~CLTS~~] CoLTS MCO 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 MCO, HSD or the [~~CLTS~~] CoLTS MCO shall reimburse the providers approved by the MCO if a donor organ becomes available for the member during the first 30 days under fee-for-service medicaid. Providers who deliver these services shall be eligible and willing to enroll as medicaid fee-for-service providers.

(5) For newly enrolled members, the MCO/SE shall pay for prescriptions for drug refills for the first 30 days or until the MCO/SE has made other arrangements. All drugs prescribed by a licensed behavioral health provider shall be paid for by the SE.

(6) For members who recently became exempt from managed care, HSD shall pay for prescriptions for drug refills for the first 30 days under the fee-for-service formulary. The pharmacy provider shall be eligible and willing to enroll as a medicaid fee-for-service provider.

(7) The MCO shall pay for DME costing $2,000 or more, approved by the MCO but delivered to the member after disenrollment from managed care or enrollment into [~~CLTS~~] CoLTS.

(8) HSD or the [~~CLTS~~] CoLTS MCO shall pay for DME costing $2,000 or more, approved by HSD or the CLTS MCO but delivered to the member after enrollment in the MCO. The DME provider shall be eligible for and willing to enroll as a medicaid fee-for-service provider. DME is not covered by the SE unless it has been prescribed by a behavioral health provider.

C. **Special payment requirement.** The MCO shall be responsible for payment of covered physical health services, provided to the member for any month the 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 an MCO's/SE's contract with HSD or the collaborative has ended, is not renewed or is terminated, the MCO/SE shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's/SE's contract has ended.

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

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

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

[8.305.16.9 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 17 VALUE ADDED SERVICES

8.305.17.9 VALUE ADDED SERVICES: The MCO/SE shall offer members value added services. The cost of these services cannot be included when HSD determines the payment rates. Value added services are not included in the managed care medicaid 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. The MCO/SE shall work with HSD to identify codes to be used for value added services. Value added services shall be direct services, not administrative in nature unless approved by HSD.

A. **Potential value added services (MCO only):** The following are suggested [~~enhanced~~] 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) child birth education, parenting skills classes;
(3) child abuse and neglect prevention programs;
(4) stress control programs;
(5) car seats for infants and children;
(6) culturally-traditional indigenous healers and treatments;
(7) smoking cessation programs;
(8) weight loss and nutrition programs;
(9) violence prevention services;
(10) substance abuse prevention and treatment, beyond the benefit package; and
(11) respite care for care givers.

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 MCO/SE's discretion. Eligibility for value added services may be based upon a set of assessment criteria to be employed by the MCO/SE.

[8.305.17.9 NMAC - N, 7-1-07; A, 7-1-08; A, 7-1-09]