State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
STATE COVERAGE INSURANCE

III. PROGRAM AFFECTED
(TITLE XIX and TITLE XXI) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Medical Assistance Division is proposing amendments to the State Coverage Insurance (SCI) rules, to be effective May 14, 2010, to include relevant language pertaining to the new Medicaid Demonstration Waiver Section 1115 as required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) and to effect various other minor revisions to clarify regulatory language.

VI. REGULATIONS
These proposed regulation changes refer to 8.200.430 NMAC, 8.262.400 NMAC, 8.262.500 NMAC, 8.262.600 NMAC, 8.306.1 NMAC, 8.306.2 NMAC, 8.306.3 NMAC, 8.306.4 NMAC, 8.306.5 NMAC, 8.306.6 NMAC, 8.306.7 NMAC, 8.306.8 NMAC, 8.306.9 NMAC, 8.306.10 NMAC, 8.306.11 NMAC, 8.306.12 NMAC, 8.306.13 NMAC, 8.306.14 NMAC, 8.306.15 NMAC, and 8.306.16 NMAC of the Medical Assistance Program Manual. This register and the proposed changes are available on the Medical Assistance Division web site at http://www.hsd.state.nm.us/mad/registers/. The proposed regulations are attached. 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 May 14, 2010.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 9:00 a.m. on March 29, 2010 in the Rio Grande Room of the Toney Anaya Building, 2550 Cerrillos Road, 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:

Kathryn Falls, Secretary-Designate
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 p.m., on March 29, 2010. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons may also address comments via electronic mail to: Magdalena.Romero@state.nm.us .

X. PUBLICATIONS

Publication of these regulations approved by:

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KATHRYN FALLS, SECRETARY-DESIGNATE
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 200 MEDICAID ELIGIBILITY - GENERAL RECIPIENT POLICIES
PART 430 RECIPIENT RIGHTS AND RESPONSIBILITIES

8.200.430.16 RECIPIENT FINANCIAL RESPONSIBILITIES: Providers who participate in medicaid agree to accept the amount paid as payment in full, see 42 CRF 447.15, with the exception of co-payment amounts required in certain medicaid categories. Other than the co-payments, a provider cannot bill a recipient for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error or failure of multiple providers to communicate eligibility information. Native Americans are exempt from co-payment requirements.

A. **Failure to follow managed care policies:** A recipient must be aware of the physicians, pharmacies, hospitals, and another provider who participate in their health maintenance organization (HMO) or other managed care plan. A recipient is responsible for payment for services if he uses a provider who is not a participant in his plan or if he receives any services without complying with the rules, policies, and procedures of the plan.

B. **Denied emergency room claims:** A recipient is responsible for payment of a hospital outpatient emergency room claim if a determination is made by MAD or its designee that an emergency did not exist at the time the service was furnished.

(1) A provider can bill the recipient directly for the denied emergency room charge.

(2) The recipient cannot be billed for denied ancillary services, such as laboratory and radiology services.

C. **Other recipient payment responsibilities:** If all the following conditions are met before a service is furnished, a recipient can be billed directly by a provider for services and is liable for payment:

(1) the recipient is advised by a provider that the particular service is not covered by medicaid or are advised by a provider that he is not a medicaid provider;

(2) the recipient is informed by a provider of the necessity, options, and charges for the services and the option of going to another provider who is a medicaid provider; and

(3) the recipient agrees in writing to have the service provided with full knowledge that he is financially responsible for the payment.

D. **Co-payment responsibility for SCHIP and WDI recipients:** It is the recipient's responsibility to pay the co-payment to the provider. Children eligible for category 032 with family income between 185-235% of poverty (SCHIP) and working disabled individuals (WDI), category 043, will have co-payment requirements as follows:

(1) WDI

(a) $7 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;

(b) $7 per dental visit;

(c) $20 per emergency room visit;

(d) $30 per inpatient hospital admission;

(e) $5 per prescription, applies to prescription and non-prescription drug items.

(2) SCHIP

(a) $5 per outpatient physician visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session, or behavioral health session;

(b) $5 per dental visit;

(c) $15 per emergency room visit;

(d) $25 per inpatient hospital admission;

(e) $2 per prescription, applies to prescription and non-prescription drug items.

E. **Co-payment exclusions:** Certain services and populations are exempt from co-payment responsibilities.

(1) Preventive, prenatal care services and contraceptive management services are exempt from the copayment requirement.

(2) Services provided at Indian health service facilities, by urban Indian providers and by tribal 638s are also exempt from the co-payment requirement.

(3) There is no co-payment required during presumptive eligibility or retroactive eligibility periods.

(4) There is no co-payment required for services provided to Native Americans.

F. **Co-payment maximum for SCHIP and WDI:** It is the responsibility of the family to track and total the co-payments paid. Once the family yearly maximum amount for SCHIP and WDI recipients has been paid

by the family via co-payments on medicaid covered services, the recipient must notify the medical assistance division. Verification must be provided to the medical assistance division that the co-payment maximum for SCHIP and WDI recipients has been paid. The first month that co-payments will no longer be required by the SCHIP and WDI recipient is the month following the month in which it has been verified by the medical assistance division that the maximum amount has been met. If the determination is made after the 25th of the month, the change is made effective the second month after the request. No retroactive eligibility for the "met co-payment maximum" criteria is allowed. Subsequent to establishing that the co-payment maximum amount has been met, the WDI recipient and the family of SCHIP recipients is not responsible for payment of co-payments for the remainder of that calendar year.

(1) Co-payment maximum amounts for SCHIP recipients are calculated at initial determination and re-determination of eligibility by ISD. The co-payment maximum amount calculated at the re-determination is effective for the following year.

(2) If the family income decreases to below 185% of federal income poverty guidelines, the family may report that change and have the children changed to category 032 eligibility up to 185% of poverty, with no co-payment requirements. The change is effective in the month following the month of such determination. If the determination is made after the 25th of the month, the effective date of the change is the second month after such verification.

(3) The family maximum co-payment amounts for SCHIP recipients are as follows:

(a) families with income between 185-200% FPL- maximum is 3%

(b) families with income between 201-215% FPL- maximum is 4%

(c) families with income between 216-235% FPL- maximum is 5%

(4) The co-payment maximum varies depending on the recipient's earned and unearned income. Once the recipient has reached his co-payment maximum on covered medicaid services, co-payments cease for the rest of that calendar year, only after the recipient has fulfilled the required steps. For SCHIP, see Paragraph (5) of Subsection A of Section 16 of 8.200.430 NMAC; for WDI, see Section 9 of 8.243.600 NMAC.

(5) Co-payment maximum amounts for WDI recipients are calculated at initial determination, based on the income received the first month of eligibility, and every twelve months thereafter. The co-payment maximum amount calculated at the initial determination is prorated for the rest of the calendar year and is also determined for the following calendar year. At each annual periodic review, the co-payment maximum will be calculated for the following calendar year.

(a) Recipients with earned and unearned income below 100% FPL - maximum is $600.

(b) Recipients with earned and unearned income between 100-250% FPL - maximum is $1500.

G. **Co-payment responsibility for state coverage insurance (SCI) recipients:** It is the recipient's responsibility to pay the co-payment to the provider. Adults eligible for category 062 with family income from 0-200% of federal poverty limit will have co-payment responsibility as follows:

Service	Co-pay at 0% - 100% FPL- 062	Co-pay at 101% - 150% FPL-062	Co-pay at 151% - 200% FPL-062
Physician/provider visits (no co-pay for preventive services-see below)	$0	$5	$7
Pre/post natal care	$0	$0	$0
Preventive services	$0	$0	$0
Hospital inpatient medical/surgical	$0/day	$25 per admission	$30 per admission
Hospital inpatient maternity	$0/day	$25 per admission	$30 per admission
Hospital outpatient surgery/procedures	$0	$5	$7
Home health	$0	$5	$7
PT, OT & SLP	$0	$5	$7
Diagnostics (excluding routine lab and x-ray)	$0 (included in office visit)	$0 (included in office visit)	$0 (included in office visit)
DME/supplies	$0	$5	$7
Emergency services	$0	$15 per visit, waived if admitted	$20 per visit, waived if

		to a hospital within 24 hours	admitted to a hospital within 24 hours
Urgent care	$0	$5	$7
Prescription drugs: generic name brand	$3 per prescription	$3 per prescription	$3 per prescription
Behavioral health and substance abuse: outpatient office visit and outpatient substance abuse treatment inpatient behavioral health and inpatient detox	$0 $0	$5 $25	$7 $30
Limits on out-of-pocket expenses	Out of pocket charges for all participants will be limited to 5% of countable family income per benefit year. [~~Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.~~]		

H. **Co-payment exclusions for SCI recipients:** Certain services and populations are exempt from co-payment responsibilities.

(1) Prenatal care services are exempt from the co-payment requirement.

(2) Services provided at Indian health service facilities, by urban Indian providers and by tribal 638s are also exempt from the co-payment requirement.

(3) <u>There is no co-payment required for services provided to Native Americans.</u>

I. **Cost-sharing maximum for SCI recipients:** It is the responsibility of the client to track and total the co-payments and the employee portion of the premiums paid. If required, the employer portion of the premium is not counted toward the cost-sharing maximum and must be paid by (or on behalf of) the individual enrollee each month regardless of income category or cost-sharing maximum status. Once the yearly maximum amount for SCI recipients has been paid by the individual via co-payments and the employee portion of the premiums on covered services, the recipient must notify the managed care organization (MCO) in which he or she is enrolled. It is the client's responsibility to notify the MCO and provide verification to the MCO that the cost-sharing maximum for SCI has been paid. The first month that cost-sharing will no longer be required by the SCI recipient is the month following the month in which it has been verified by the MCO that the maximum amount has been met. If the determination is made after the 24th of the month, the change is made effective the second month after verification. No retroactive eligibility for the "met cost-sharing maximum" criteria is allowed. Subsequent to establishing that the cost-sharing maximum amount has been met, the SCI recipient is not responsible for payment of co-payments and employee portion of the premiums for the remainder of that benefit year. Co-payment maximum amounts for SCI recipients are calculated at initial determination and re-determination of eligibility by ISD at 5% of the annual countable income. The co-payment maximum amount calculated at the re-determination is effective for the following benefit year. See also 8.262.600.9 NMAC.

J. Premium payments, when required, must be paid in full each month, even if cost-sharing maximum has been reached and there is an overpayment. No partial payments of premiums or co-payments will be allowed. No premiums or co-payments will be refunded.

[2-1-95, 3-1-99, 7-1-00; 8.200.430.16 NMAC - Rn, 8 NMAC 4.MAD.437 & A, 1-1-01; A, 1-1-02; A, 6-1-04; A, 6-15-04; A, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 5-14-10]

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

8.262.400.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2 authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.262.400.3 NMAC - N, 7-1-05; A, 5-14-10]

8.262.400.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver[~~,~~] and the medicaid demonstration waiver and subject to availability of funds.
[8.262.400.4 NMAC - N, 7-1-05; A, 5-14-10]

8.262.400.7 DEFINITIONS:

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

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

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

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

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

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

G. **Childless adult population:** Non-pregnant, childless adults, ages 19 through 64 years, with household income below 200 percent of the federal poverty level, who do not otherwise qualify for medicaid or medicare.

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

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

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

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

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

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

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

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

[~~O.~~] P. **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care coverage. Enrollment encompasses selection of

an MCO, notification of the selection to the MCO, and timely payment of premiums, as required, as designed by the MCO.

[~~P.~~] Q. **Eligibility letter:** A notice of SCI eligibility and the potential for SCI coverage contingent upon enrollment with a SCI participating MCO. The letter will include start and end dates of eligibility, the requirement to enroll before coverage will begin, and the need to enroll 90 days subsequent to the month of issuance of the enrollment letter. The letter will also notify the member of the federal poverty level subcategory and of the responsibility to track out-of-pocket expenditures for SCI cost sharing.

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

(1) father (biological or adopted);
(2) mother (biological or adopted);
(3) grandfather, great grandfather, great-great-grandfather, great-great-great-grandfather;
(4) grandmother, great grandmother, great-great-grandmother, great-great-great-grandmother;
(5) spouse of child's parent (stepparent);
(6) spouse of child's grandparent, great grandparent, great-great-grandparent, great-great-great-grandparent (step-grandparent);
(7) brother, half-brother, brother-in-law, stepbrother;
(8) sister, half-sister, sister-in-law, stepsister;
(9) uncle of the whole or half blood, uncle-in-law, great uncle, great-great uncle;
(10) aunt of the whole or half-blood, aunt-in-law, great aunt, great-great aunt;
(11) first cousin and spouse of first cousin;
(12) son or daughter of first cousin (first cousin once removed) and spouse;
(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or
(14) nephew/niece and spouses.
(15) ***Note:*** A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

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

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

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

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

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

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

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

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

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

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

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

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

EE. **Parent population:** Uninsured parents, ages 19 through 64, of medicaid and CHIP-eligible children, who are not otherwise eligible for medicaid or medicare, with household below 200 percent of the federal poverty level.

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

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

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

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

[~~HH.~~] JJ. **SCI (state coverage insurance):** The New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver and a section 1115 medicaid demonstration waiver granted to the state by the centers for medicare and medicaid services (CMS).

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

[~~JJ.~~] LL. **Voluntary drop:** The act of voluntarily terminating or discontinuing health insurance coverage.
[8.262.400.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 6-1-08; A, 7-1-09; A, 5-14-10]

8.262.400.17 SPECIAL RECIPIENT REQUIREMENTS:

A. **Age:** To be eligible for SCI, an individual must be age 19 through 64.

B. **Continuing eligibility on the factor of age:** When an individual has been determined eligible on the condition of age, he remains eligible on the condition until the applicable upper age limit is reached. An individual who exceeds the age limit during a given month is eligible for that month, unless the birthday is the first day of the month.

C. **Uninsured:** For purposes of SCI eligibility, an individual cannot have health insurance coverage, excluding catastrophic or supplemental health insurance policies. An individual with access to health care at Indian health services, veteran's administration, or through worker's compensation, is not considered to be insured for purposes of this program by having such access.

D. **Enrolled:** An individual who has been determined eligible for SCI must notify an SCI-contracted MCO and must have made and continue to make premium payment as a condition of SCI coverage.

E. **Premium payment**: SCI requires payment of premiums by the employer at a rate established by the department, and by the employee per month as calculated by income level: 062A, 062B and 062C. Some individuals may be required to pay both the employers and employee's share based on income level. Nothing in this section prevents another entity from contributing the employer or employee premium share on behalf of an individual member. Nothing in this section prevents the employer or a third party from paying the employee portion of the premium on behalf of the employee. The due date of premium payments will be determined by the MCO. If an individual's category of SCI eligibility changes at annual recertification for the program, resulting in a different premium payment due, the new premium amount is effective beginning with the first month of the new recertification approval period. Individuals who fail to pay the premium within the timeframe established by the MCO may be disenrolled.

F. **Voluntary drop of health insurance:** An individual who has voluntarily dropped health insurance will be ineligible for SCI for six months, starting with the first month the health insurance was dropped (i.e., the first month of no coverage). An employer who has voluntarily dropped health insurance will be ineligible to enroll employees in SCI for twelve months. The following circumstances are not considered a voluntary drop:

(1) an individual (or spouse) fails to take advantage of an initial offer of health insurance by an employer (unless the insurance is SCI coverage), or fails or refuses to take advantage of a COBRA continuation policy;

(2) loss of access to employer-sponsored insurance due to loss of employment, divorce, death of a spouse, or geographic move, loss of coverage as a dependent child, or loss of medicaid eligibility; or

(3) an employee enrolled in an individual health plan whose employer is offering SCI employer-sponsored insurance (as an initial offering or at open enrollment) will be able to participate in SCI under group coverage and will not be considered to have voluntarily dropped health insurance in order to participate in the SCI employer group plan.

(4) an individual who was covered under SCI within the most recent 12 months and had reached the annual benefit maximum and was transitioned to the New Mexico medical insurance pool, will be able to re-enroll in SCI at his/her annual SCI recertification period.

G. **Cost-sharing maximums:** An SCI-covered individual is responsible for tracking and reporting of the cost-sharing amount paid in a benefit year, and for reporting to the managed care organization (MCO) when the cost-sharing maximum amounts are met (also known as "shoebox methodology"). The first month of coverage without cost-sharing will be the month after the month of verification that the maximum expenditure limit has been met, unless the determination is made after the 24th of the month. Where the determination is made after the 24th of the month, the first month of coverage without cost-sharing will be the second month after verification. The period of coverage without cost-sharing will end on the last day of that benefit year. No partial payments of premiums or of copayments will be allowed. No premiums or copayments will be refunded.

[8.262.400.17 NMAC - N, 7-1-05; A, 4-16-07; A/E, 8-1-07; A, 7-1-09; A, 5-14-10]

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

8.262.500.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2 authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) wavier under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.262.500.3 NMAC - N, 7-1-05]

8.262.500.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.262.500.4 NMAC - N, 7-1-05]

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 600 BENEFIT DESCRIPTION

8.262.600.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter27, Articles 1and 2) authorize the state to administer the medicaid program. The state was granted a [~~5-year~~] health insurance flexibility and accountability (HIFA) waiver under Section 1115 of the Social Security Act and a medicaid demonstration waiver under Section 1115, both subject to certain terms and conditions. The state is using [~~the~~] waiver authority to implement the State Coverage Insurance (SCI program). The SCI program offers a basic benefit package to adults with countable income of less than 200[~~%~~] percent of the federal poverty level. There is no fee-for-service coverage under SCI. The benefits begin after enrollment with one of the contracted managed care organizations.
[8.262.600.3 NMAC - N, 7-1-05; A, 5-14-10]

8.262.600.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.262.600.4 NMAC - N, 7-1-05; A, 5-14-10]

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

8.306.1.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.1.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.1.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.1.4 NMAC - N, 7-1-05; A, 5-14-10]

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

A. Definitions beginning with letter "A":

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

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

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) of an MCO action as defined above in Paragraph (2) of Subsection A of 8.306.1.7 NMAC.

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

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

B. Definitions beginning with letter "B":

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

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

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

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

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

(6) **Broker:** A person, partnership, corporation or professional corporation appointed by a health insurer licensed to transact business in New Mexico to act as its representative in any given locality for the purpose

of soliciting and writing any policy or contract insuring against loss or expense resulting from the sickness of the insured.

C. Definitions beginning with letter "C":

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

(2) **Care coordination:** An office-based administrative function to assist members "at risk" for adverse outcomes to help meet their needs by filling in gaps in current health care on an as needed basis. Care coordination is member-centered, family-focused when appropriate, culturally competent and strengths-based, and ensures that the medical and behavioral health needs of the SCI population are identified and 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, other program personnel, and family; facilitating access to services; actively managing transitions of care, such as a hospital discharge; training of caregivers; and ongoing reassessment and refinement of the care plan. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances. Clinical decisions shall be based on the medically necessary covered services and not on fiscal or administrative considerations. The care coordinator coordinates services within the physical and behavioral health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, or refer the member to case management as necessary. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Case management**: Case management consists of services which help beneficiaries gain access to needed physical health, behavioral health, social, educational, and other services. A person or team of people who provide outreach to customers, provide information to them about services, work with them to develop a service plan, assist in obtaining needed services, supports and entitlements and advocate on their behalf. General case management is designed to access, coordinate and monitor services.

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

(5) **Childless adult population:** Non-pregnant, childless adults, ages 19 through 64 years, with household income below 200 percent of the federal poverty level, who do not otherwise qualify for medicaid or medicare.

[~~(5)~~] (6) **Clean claim:** A manually or electronically submitted claim from a participating provider that contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside the health plan's system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. A clean claim is not materially deficient or improper, such as lacking substantiating documentation currently required by the health plan, or has no particular or unusual circumstances requiring special treatment that prevents payment from being made by the health plan within 30 days of the date of receipt if submitted electronically or 45 days if submitted manually.

[~~(6)~~] (7) **Client:** An individual who has applied for and been determined eligible for SCI. A "client" may also be referred to as a "member," "customer," or "consumer", or "program participant".

[~~(7)~~] (8) **CMS:** Centers for medicare and medicaid services.

[~~(8)~~] (9) **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.

[~~(9)~~] (10) **Comprehensive community support services**: These services are goal-directed mental health rehabilitation services and support 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.

[~~(10)~~] (11) **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.

[~~(11)~~] (12) **Coordination of long-term services (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) waivers. The 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 CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities and medically-fragile waiver programs.

[~~(12)~~] (13) **Cost-sharing:** Premiums and co-payments owed by the member based on income group category.

[~~(13)~~] (14) **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to five percent of the program participant's countable household income.

[~~(14)~~] (15) **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable are met.

[~~(15)~~] (16) **Cultural competence:** Cultural competence refers to a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals, that enables them to work effectively in cross-cultural situations. Cultural competency involves the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards, skills, service approaches, techniques and marketing programs that match an individual's culture and increase the quality and appropriateness of health care and outcomes.

D. Definitions beginning with letter "D":

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

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by SCI, not being on the MCO pharmacy drug list, or due to provider noncompliance with administrative policies and procedures established by either the SCI MCO or the medical assistance division.

(3) **Denial-clinical:** A non-authorization decision at the time of an initial request for a SCI service or a pharmacy drug list request based on the member not meeting medical necessity for the requested service. The utilization management (UM) staff may recommend an alternative service, based on the member's need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

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

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

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

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

E. Definitions beginning with letter "E":

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

(2) **Employer:** An employer with 50 or fewer eligible employees on a full or part time basis.

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

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

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

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

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

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

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

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

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

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

G. Definitions beginning with letter "G":

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

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

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

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

H. Definitions beginning with letter "H":

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

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

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

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

I. Definitions beginning with letter "I":

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

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

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

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

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

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

M. Definitions beginning with letter "M":

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

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

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

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

(5) **Medically necessary services:**

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

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

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

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

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

(b) Application of the definition:

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

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

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

(6) **Member:** A eligible member enrolled in an MCO.

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

(8) **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 to furnish physical or behavioral health services to the MCO's members under the provisions of the SCI managed care contract.

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

O. Definitions beginning with letter "O": **Outreach:** The act or process of promoting an insurance product through established business channels of communications including brochures, leaflets, internet, print

media, electronic media, signage or other materials used by MCOs to attract or retain SCI enrollment primarily through employer groups.

P. Definitions beginning with letter "P":

(1) **Parent population:** Uninsured parents, ages 19 through 64, of medicaid and CHIP-eligible children, who are not otherwise eligible for medicaid or medicare, with household income below 200 percent of the federal poverty level.

[~~(1)~~] (2) **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

[~~(2)~~] (3) **Pend decision:** A prior authorization decision is considered pended when the decision is delayed due to lack of documentation, inability to contact parties involved or other reason which delays finalizing an approval. A decision by an MCO to pend approval does not extend or modify required utilization management decision timelines.

[~~(3)~~] (4) **Performance improvement project (PIP):** An MCO program activity must include projects that are designed to achieve significant improvement in clinical or non-clinical care areas. PIPs must involve measurements using objective quality indicators, system intervention to achieve improvement, evaluation of the effectiveness of interventions and activities for increasing or sustaining improvement. Outcomes must be measurable over a period of time.

[~~(4)~~] (5) **Performance measurement (PM):** Data specified by the state that enables the MCO's performance to be determined.

[~~(5)~~] (6) **Plan of care:** A written document including all medically necessary services to be provided by the MCO for a specific member.

[~~(6)~~] (7) **Policy:** The statement or description of requirements.

[~~(7)~~] (8) **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.

[~~(8)~~] (9) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~(9)~~] (10) **Preventative health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(10)~~] (11) **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.

[~~(11)~~] (12) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

[~~(12)~~] (13) **Procedure:** Process required to implement a policy.

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

R. Definitions beginning with letter "R":

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

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

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

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

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

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

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

S. Definitions beginning with letter "S":

(1) **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 meet eligibility requirements.

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

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

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

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

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

T. Definitions beginning with letter "T":

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

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

(3) **Transition of care:** Refers to the movement of patients from one health care practitioner or setting to another as their condition and care requires 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 the letter "V": **Value added benefit:** Any benefit offered to members by the MCO that is not included in the SCI benefit package.

[8.306.1.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 6-1-08; A, 7-1-09; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 10 ENCOUNTERS

8.306.10.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.10.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.10.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.10.4 NMAC - N, 7-1-05; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 11 REIMBURSEMENT

8.306.11.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The state coverage insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.11.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.11.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.11.4 NMAC - N, 7-1-05; A, 5-14-10

8.306.11.9 REIMBURSEMENT:

A. MCO and HSD shall comply with 8.305.11.9 NMAC, *reimbursement for managed care* for the SCI program with the exception of SCI members who are hospitalized at the time of disenrollment from SCI (see below Subsection B of 8.306.11.9 NMAC). Rates negotiated between HSD and the MCO are considered confidential.

B. **SCI members who disenroll while hospitalized**: If the member is hospitalized at the time of disenrollment from SCI, or upon an approved switch from one SCI contractor to another, the contractor at the time of admission remains responsible for all covered or approved services until the earliest of: the date of discharge, date of switch to another contractor, date of the member's termination/disenrollment or until the maximum benefit limits are reached.

C. **Payment of premiums:** In addition to capitation payments from HSD, the MCO shall receive premium payments as specified by HSD. Premiums will be paid as follows:

(1) **employer premium** amount determined by department; and

(2) **employee or individual premium** determined by department based on the federal poverty limits as follows: 0-100 percent per month, 101-150 percent per month, 151-200 percent per month,

D. **Premium timeframes:** Initial premiums are due to the MCO immediately upon enrollment and prior to the 1st day of the month before coverage begins. An employer group or individual member can only receive coverage when the premium has been paid. Capitation payments will not be paid unless verification of premium payment through the roster is received. If payment is not current within that timeframe, the employer group or individual member will not be covered for the next month and will not be able to enroll in an SCI MCO for a period of twelve months for an employer group or six months for an individual member.

E. **Responsibility for premium payment:** For members in an employer group, the employer shall be responsible for ensuring payment of the employer and employee share (if any) of premiums. For individuals who are not affiliated with an employer group, the individual or an entity paying on behalf of an individual [~~shall~~] may be responsible for payment of both the employer and individual premium amount (if any). If a member who is part of an employer group has met the cost-sharing maximum, as verified by the MCO, HSD shall be responsible for payment of the member's; but not the employer's share of premiums. For individual members not in an employer group who have met the cost-sharing maximum, HSD shall be responsible for the member's share of the premium. The member will continue to be responsible for the employer's share of the premium, when required.
[8.306.11.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 7-1-09; A, 5-14-10]

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

8.306.12.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.12.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.12.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.12.4 NMAC - N, 7-1-05; 5-14-10]

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

8.306.13.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the SCI program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.13.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.13.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.13.4 NMAC - N, 7-1-05; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 14 REPORTING REQUIREMENTS

8.306.14.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the SCI program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.14.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.14.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and Medicaid demonstration waiver, and subject to availability of funds.
[8.306.14.4 NMAC - N, 7-1-05; A, 5-14-10]

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

8.306.15.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.15.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.15.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and Medicaid demonstration waiver, and subject to availability of funds.
[8.306.15.4 NMAC - N, 7-1-05; A, 5-14-10]

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

8.306.16.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The state coverage insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.16.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.16.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.16.4 NMAC - N, 7-1-05; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 2 MEMBER EDUCATION

8.306.2.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.2.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.2.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.2.4 NMAC - N, 7-1-05; A, 5-14-10]

8.306.2.9 MEMBER EDUCATION: SCI members shall be advised of their rights, responsibilities, service availability and administrative roles under SCI. Member education is initiated when a member becomes eligible for SCI with information provided by HSD and the managed care organization (MCO).

A. **Initial information:** Various outreach and media strategies are designed to reach employers, employees, as well as non-employed individuals; to ensure that all eligible New Mexicans are aware of the availability of SCI. Marketing is especially targeted to employers not currently offering insurance as well as to employers who offer insurance but whose employees cannot afford the required premium sharing. Initial member education is provided by the MCO and brokers and through outreach materials available from HSD.

B. **MCO enrollment information:** Once an individual enrollee or employee is determined to be eligible for the SCI program, his employer, broker, or MCO will provide the member information about services included in the MCO benefit package.

C. **Informational materials:** The MCO 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 languages other than English, if there is a greater than five percent incidence of another language spoken within the MCO membership as determined by the MCO or HSD.

(1) The member handbook shall include the following:

(a) MCO 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) patient 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;

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

(f) the amount, duration and scope of benefits;

(g) information on accessing behavioral health or other specialty services,

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

(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 medical opinion;

(o) information on cost sharing, cost sharing maximums and maximum benefit amounts per benefit year;

(p) how to obtain information, 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) information regarding the birthing option program; and

(r) language that clearly explains that a Native American SCI member may self-refer to an Indian health service or tribal health care facility for services.

(2) The provider directory shall include the following:

(a) MCO addresses and telephone numbers;

(b) a listing of primary care and self-refer specialty providers with the name, location, phone number, and qualifications including areas of special expertise and non-English languages spoken that would be helpful to members; MCO-contracted specialty providers for self-referral shall include, but not be limited to, point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service, and tribal health care providers including hospitals, outpatient clinics, and pharmacies; and

(c) the material shall be available in a manner and format that can be easily understood by all populations who exceed a greater than five percent incidence in the total MCO membership as identified by the MCO and HSD.

D. **Other requirements:**

(1) The MCO shall provide the member handbook and provider directory to enrolled members 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, 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 shall have a process in place for notifying members of the availability of this information in alternative formats.

(3) Oral and sign language interpretation shall be made available free of charge to members and to potential members, upon request, and be available in non-English languages for populations that exceed a greater than five percent incidence within the MCO's membership as defined by the MCO and HSD.

(4) The member handbook shall be approved by HSD prior to distribution to SCI members.

(5) Notification of material changes in the administration of the MCO, changes in the MCO'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 shall make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice.

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

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

E. **MCO policies and procedures on member education:** The MCO 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 used. The MCO 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 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. The MCO shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors. HSD approval of health education materials is not required.

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

[8.306.2.9 NMAC - N, 7-1-05; A, 7-1-09; A, 5-14-10]

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

8.306.3.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The state coverage insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.3.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.3.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.3.4 NMAC - N, 7-1-05; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 4 ELIGIBILITY

8.306.4.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The state coverage insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.4.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.4.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.4.4 NMAC - N, 7-1-05; A, 5-14-10]

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

8.306.5.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both, subject to special terms and conditions.
[8.306.5.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.5.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.5.4 NMAC - N, 7-1-05; A, 5-14-10

8.306.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The managed care organization (MCO) shall provide [~~an open~~] a defined enrollment period during which the MCO will enroll individuals in accordance with accepted MCO practice in the order in which they apply, up to the limits contained in the contract or based upon enrollment limits set forth in the demonstration waivers. 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 disability, race, color, national origin, or sexual orientation. The MCO shall not use any policy or practice that has the effect of discriminating on the basis of disability, race, color, national origin, or sexual orientation. All enrollments shall be voluntary and based on member or employer choice.

B. **Member lock-in:** Except as otherwise provided below, once a member in an employer group has enrolled in an MCO through his employer group, he may only transfer to another MCO, 1) during the employer enrollment period, that occurs when the employer contracts with another MCO; or 2) if he changes employers. A member enrolled individually may only transfer to another MCO when his eligibility is recertified or "for cause" as defined as follows: the following criteria shall be cause for transfer:

(1) continuity of care issues;
(2) family continuity;
(3) administrative or data entry error in assigning a client to an MCO;
(4) assignment of a member where travel for primary care exceeds community standards (90 percent of urban residents shall travel no further than 30 miles to see a PCP; 90 percent of rural residents shall travel no further than 45 miles to see a PCP; and 90 percent 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; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

C. **Selection period:** After receiving a letter of eligibility from the ISD office or an enrollment packet from the MCO, a new individual member shall complete enrollment with an MCO within a 90 day period. If enrollment, including payment of any required premium, is not made within that timeframe, the member shall be considered to have voluntarily dropped the SCI insurance coverage, which means that the individual may not enroll with an SCI MCO for six months, beginning with the individual's eligibility start date. An employer group has a specified time period, determined by the MCO and HSD, in which to complete enrollment and premium payment with an SCI MCO after all employees have received their letters of eligibility. Failure of the employer to complete

the enrollment process within this time period will deem the employer to have voluntarily dropped insurance coverage and the employer will be ineligible to enroll with an SCI MCO for a 12-month period; however, the individual employees are eligible to enroll immediately as individuals and will not be considered to have voluntarily dropped health insurance coverage.

D. **Beginning date of enrollment:** Enrollment begins the first day of the first full month following receipt of eligibility letter and MCO completion of enrollment including receipt of required premiums. However, if MCO receipt of required premium payment occurs after the HSD-approved designated day of the month and before the first full day of the following month, the enrollment begins on the first day of the second full month after MCO receipt of premium payments.

E. **Member switch enrollment:** A member enrolled as an individual and not as an employee enrolled through an employer group may request to be disenrolled from an MCO and switch to another MCO (if available) "for cause" at any time. The request shall be made in writing to HSD. HSD shall review the request and furnish a written response to the member and the MCO in a 30 day period. The following criteria shall be used to make a decision regarding a switch enrollment request:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in enrolling a member with an MCO;

(4) travel for primary care exceeds community standards, (90 percent of urban residents shall travel no further than 30 miles to see a PCP; 90 percent of rural residents shall travel no further than 45 miles to see a PCP; and 90 percent 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; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

F. **Disenrollment, MCO initiated:** The MCO may request that a particular member be disenrolled. Other than for non-payment of premiums, member disenrollment from an MCO will be considered only in rare circumstances. Disenrollment requests shall be made in writing to HSD. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another SCI-contracted MCO. If the member is part of an employer group and the employer does not contract with another MCO, HSD may allow the member to enroll with another MCO, but the member shall be responsible for the employer's premium share, if required. The MCO shall assist with transition of care to the other MCO.

G. **Conditions under which an MCO requests member disenrollment:** The MCO may not seek to terminate enrollment because of an adverse change in the member's health. The MCO 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 seriously impairs the MCO's ability to furnish services to either this particular member or other members. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another MCO. The MCO shall assist with transition of care.

H. **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 available contracted MCOs, HSD shall evaluate the member for termination from SCI.

I. **Date of disenrollment:** MCO enrollment shall terminate at the end of the month following the month in which HSD approval for disenrollment is granted.
[8.306.5.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 7-1-09; A, 5-14-10]

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TITLE 8 SOCIAL SERVICES

CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 6 PROVIDER NETWORKS

8.306.6.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.6.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.6.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.6.4 NMAC - N, 7-1-05; A, 5-14-10]

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

8.306.7.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.7.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.7.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.7.4 NMAC - N, 7-1-05; A, 5-14-10

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

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

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

(j) rehabilitative services - physical, occupational, and speech therapy;
(k) administration of whole blood, blood plasma, and components;
(l) discharge planning and coordination of services; and
(m) maternity care.

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

(1) can reasonably be provided on an ambulatory basis;

(2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;

(3) require prior authorization, unless otherwise noted; and

(4) the following provides additional information on covered outpatient services and associated co-payments:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) office visits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(8) Periodic colon examination of 35 to 60 centimeters or barium enema for all persons 45 years of age or older.

(9) Voluntary family planning services.

(10) Insertion of contraceptive devices.

(11) Removal of contraceptive devices.

(12) Surgical sterilization.

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

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

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

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

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

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

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

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

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

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

(5) Home intravenous services are covered.

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

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

(1) Prior authorization is required.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

S. **Limitations on coverage:** The benefit package is limited to $100,000 in benefits payable per member per benefit year. The state may adjust the $100,000 maximum per benefit year; however the maximum per benefit year cannot be decreased more than five percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than $100,000. The state must notify CMS 60 days prior to any requested change in the maximum per benefit year.

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

[8.306.7.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09; A, 5-14-10]

8.306.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. Covered services are subject to the following conditions and limitations:

A. **Medically necessary:** Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

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

(2) 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;

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

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

B. Behavioral health and substance abuse services:

(1) Inpatient mental health services/partial hospitalizations are limited to 25 days per benefit year.

(2) Inpatient substance abuse detoxification is limited to 72 hours per occurrence as part of the total 25 day benefit for inpatient mental health services.

(3) Outpatient substance abuse detoxification services are limited to ten days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to 42 days per benefit year.

C. **Cardiovascular rehabilitation:** Coverage for cardiovascular rehabilitation is limited to a maximum of 36 sessions per cardiac event.

D. **Choice of provider:** For the purpose of coverage under this policy, the SCI MCO has the right to determine which provider may be used to provide the covered services.

E. **Contact lenses or eyeglasses following cataract surgery:** One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to $300 per surgery. Coverage for contact lenses or eyeglasses is limited to 90 days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the 90 day period are not covered.

F. **Dental services:** In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within 12 months of the date of injury. The MCO will require dental x-rays.

G. **Detoxification:** Inpatient detoxification is limited to 72 hours of inpatient services per occurrence as part of the 25 day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten days per benefit year.

H. **Home health services:** Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed 25 days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.

I. **Inpatient hospitalization, home health services, inpatient rehabilitation:** This policy is limited to maximum of 25 combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.

J. **Major disasters:** In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.

K. **Maximum benefit limits:** Maximum benefits allowed under SCI are limited to $100,000 per member per benefit year. <u>The state may adjust the $100,000 maximum per benefit year; however the maximum per benefit year cannot be decreased more than five percent in a single year and the maximum per benefit year cannot be adjusted to an amount less than $100,000. The state must notify CMS 60 days prior to any requested change in the maximum per benefit year.</u>

L. **Maternity transport:** Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.

M. **Mastectomy and lymph node dissection:** Length of inpatient stay: not less than 48 hours inpatient stay following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.

N. **Orthotic appliances and prosthetic devices:** Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

O. **Physical, speech and occupational therapy:** Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two consecutive months per member per condition.

P. **Post mastectomy supplies:** Bras required in conjunction with reconstructive surgery are limited to two (2) per member, per benefit year.

Q. **Prescription drugs:** Prescription drugs are limited to generic drugs and name brand prescriptions on the preferred drug list (PDL) drugs as listed on the MCO PDL. The MCO shall ensure that Native American members accessing prescription drugs at IHS or tribal 638 facilities will be exempt from the MCO's PDL. For each co-payment amount, quantities are limited to a 30-day supply or 100 tablets; whichever is less, per prescription or refill. All other units will be dispensed in a 30 -day supply, with one co-payment required for each of the following quantities:

(1) **Topical products:** The lesser of 80 gm. of cream/ointment or 60 ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

(2) **Oral liquids:** 480 ml. maximum per co-payment.

(3) **Inhalers and vials:** One co-payment per unit (diabetic insulin exception - two vials of the same type of insulin per co-payment).

(4) **Manufacturer's trade package:** One co-payment per trade package (i.e. imitrex, estrogen patches).

(5) **Mail order drugs** are limited to drugs available through the MCO'S mail order distributor.

R. **Transplants - organ, bone marrow, or tissue:**

(1) Organ, bone marrow, or tissue transplants are limited to:

(a) heart;

(b) heart/lung;

(c) lung;

(d) liver;

(e) cornea;

(f) kidney;

(g) skin;

(h) bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, severe combined immunodeficiency disease, wiskott-aldrich syndrome, advanced hodgkin's or non-hodgkin's lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas); or

(i) pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

(2) No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted centers of excellence if one is available.

(3) A member is eligible for coverage for up to two transplants per lifetime. Multiple organ, bone marrow, or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the $100,000 annual benefit limitation per member per benefit year.

[8.306.7.12 NMAC - N, 7-1-05; A, 7-1-09; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 8 QUALITY MANAGEMENT

8.306.8.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The state coverage insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.8.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.8.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and medicaid demonstration waiver, and subject to availability of funds.
[8.306.8.4 NMAC - N, 7-1-05; A, 5-14-10]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 9 COORDINATION OF BENEFITS

8.306.9.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.9.3 NMAC - N, 7-1-05; A, 5-14-10]

8.306.9.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.9.4 NMAC - N, 7-1-05; 5-14-10]