State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT (HSD)

II. SUBJECT
MANAGED CARE PROGRAM RULES
8.308.2 NMAC, 8.308.6 NMAC, 8.308.7 NMAC, 8.308.8 NMAC, 8.308.10 NMAC, 8.308.11 NMAC, 8.308.20 NMAC, 8.308.21 NMAC AND 8.308.22 NMAC

III. PROGRAM AFFECTED
(TITLE XIX) MEDICAID

IV. ACTION
PROPOSED RULES

V. BACKGROUND SUMMARY

The Human Services Department (the Department), through the Medical Assistance Division (MAD), is proposing to create new managed care organization (MCO) rules for the implementation of Centennial Care. These rules will govern Department's contracted managed care organizations (MCO) structure and administration of the Medical Assistance Programs. The following proposed rules will be contained in Chapter 308 of the New Mexico Administrative Code:

8.308.2	Provider Networks
8.308.6	Eligibility and Enrollment
8.308.7	Enrollment and Disenrollment
8.308.8	Member Education – Rights and Responsibilities
8.308.10	Care Coordination
8.308.11	Transition of Care
8.308.20	Reimbursement
8.308.21	Quality Management
8.308.22	Fraud, Waste and Abuse.

The Department will promulgate in subsequent registers to follow proposed MCO rules for member services and cost sharing.

VI. RULES

These proposed rules will be contained in 8.308.2 NMAC, 8.308.6 NMAC, 8.308.7 NMAC, 8.308.8 NMAC, 8.308.10 NMAC, 8.308.11 NMAC, 8.308.20 NMAC, 8.308.21 NMAC, 8.308.22 NMAC. This register and the proposed rules are available on the MAD website at http://www.hsd.state.nm.us/mad/registers/2013. If you do not have internet access, a copy of the proposed rules may be requested by contacting MAD at 505-827-3152.

VII. EFFECTIVE DATE

The Department proposes to implement these rules effective January 1, 2014.

VIII. PUBLIC HEARING

A public hearing to receive testimony on these proposed rules will be held at the Rio Grande Conference Room, Toney Anaya Building, 2550 Cerrillos Road, Santa Fe, NM on Monday, November 18, 2013 at 8:30 am.

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 MAD toll free at 1-888-997-2583 and ask for extension 7-3152. In Santa Fe, call 827-3152. 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 10 days advance notice to provide requested alternative formats and special accommodations.

Copies of all comments will be made available on December 23, 2013 by MAD upon request by providing copies directly to a requestor or by making them available on the MAD website or at a location within the county of the requestor.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Sidonie Squier, Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5 p.m. on Monday, November 18, 2013. Written and recorded comments will be given the same consideration as testimony made at the public hearing. Interested persons may address comments via telephone to 505-827-3152 or via electronic mail to: Emily.Floyd@state.nm.us.

X. PUBLICATION

Publication of these rules approved by:

SIDONIE SQUIER, SECRETARY
HUMAN SERVICES DEPARTMENT

MANAGED CARE PROGRAM
FRAUD, WASTE AND ABUSE

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MEDICAID MANAGED CARE
PART 22 FRAUD, WASTE AND ABUSE

8.308.22.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.22.1 NMAC - N, 1-1-14]

8.308.22.2 SCOPE: This rule applies to the general public.
[8.308.22.2 NMAC - N, 1-1-14]

8.308.22.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.22.3 NMAC - N, 1-1-14]

8.308.22.4 DURATION: Permanent.
[8.308.22.4 NMAC - N, 1-1-14]

8.308.22.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.22.5 NMAC - N, 1-1-14]

8.308.22.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.22.6 NMAC - N, 1-1-14]

8.308.22.7 DEFINITIONS:

A. "Credible allegation of fraud" means an allegation, which has been verified by the state, from any source, including but not limited to the following:
(1) fraud hotline complaint;
(2) claims data mining;
(3) patterns identified through provider audits;
(4) civil false claims cases; or
(5) law enforcement investigations; see 42 CFR 455.2.

B. "Fraud" means an intentional deception or misrepresentation by a person or an entity, with knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or state statutes, regulations and rules.

C. "MFEAD" is the medicaid fraud and elder abuse division of the New Mexico attorney general's office

D. "Overpayment" means any funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

E. "Provider" means a network provider and non-network provider.

F. "Recovery" means money received by HSD or MFEAD for fraud or credible allegations of fraud from a provider.

G. "Refund" means money returned by a provider for overpayment(s).
[8.308.22.7 NMAC - N, 1-1-14]

8.308.22.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.22.8 NMAC - N, 1-1-14]

8.308.22.9 FRAUD, WASTE AND ABUSE: HSD is committed to aggressive prevention, detection, monitoring, and investigation to reduce provider or member fraud, waste and abuse. This rule applies to all individuals and entities participating in or contracting with HSD or a MCO for provision or receipt of medicaid

services. If fraud, waste or abuse is discovered, HSD shall seek all remedies available to it under federal and state statutes, regulations, rules.

A. Program integrity requirements: the MCO shall have a comprehensive internal program integrity and overpayment prevention program to prevent, detect, preliminarily investigate and report potential and actual program violations including detecting potential overutilization of services, drugs, medical supply items and equipment. The MCO shall:

(1) be responsible for preventing and identifying overpayments or improper payments made to its providers;

(2) have specific internal controls for prevention, such as claim edits, prepayment and post-payment reviews, and provider profiling; and

(3) verify that services are actually provided utilizing "explanation of medicaid benefits" (EOB) notices and performing audits, reviews, and preliminary investigations.

B. Investigations and referrals: The MCO shall perform preliminary investigations of alleged fraud. The MCO shall:

(1) after conducting its preliminary investigation, submit to HSD for review all facts, supporting documentation and evidence of alleged fraud;

(2) upon request from MFEAD, release its preliminary investigation, including all supporting documentation and evidence to MFEAD and cease its investigation until otherwise advised by HSD or MFEAD;

(3) upon receipt of notification by HSD, and as directed, impose a suspension of payments to providers pending investigations of credible allegations of fraud and non release the payment suspension until notified in writing by HSD.

C. Overpayments: Are funds that a person or entity receives or retains in excess of the medicaid allowable amount; however, for purposes of this rule, an overpayment does not include funds that have been subject to a payment suspension or that have been identified as third-party liability.

(1) an overpayment shall be deemed to have been identified by a provider when:

(a) the provider reviews billing or payment records and learns that it correctly coded certain services or claimed incorrect quantities of services, resulting in increased reimbursements;

(b) the provider learns that a recipient's death occurred prior to the service date on which a claim that has been submitted for payment;

(c) the provider learns that services were provided by an unlicensed or excluded individual on its behalf;

(d) the provider performs an internal audit and discovers that an overpayment exists;

(e) the provider is informed by a governmental agency or its designee of an audit that discovered a potential overpayment;

(f) the provider is informed by the MCO of an audit that discovered a potential overpayment;

(g) the provider experiences a significant increase in medicaid revenue and there is no apparent reason for the increase, such as a new partner added to a group practice or new focus on a particular area of medicine;

(h) the provider has been notified that the MCO or a governmental agency or its designee has received a hotline call or email; or

(i) the provider has been notified that the MCO or a governmental agency or its designee has received information alleging that a member had not received services or been supplied goods for which the provider submitted a claim for payment.

(2) The MCO shall require its contracted providers to report to their MCO by the later of:

(a) the date which is 60 calendar days after the date on which the overpayment was identified; or

(b) the date any corresponding cost report is due, if applicable;

(3) The MCO shall require its providers to complete a self-report of the overpayment within 60 calendar days from the date on which the provider identifies an overpayment and require that the provider send an "overpayment report" to the MCO and HSD which includes:

(a) the provider's name;

(b) the provider's tax identification number and national provider number;

(c) how the overpayment was discovered;

(d) the reason(s) for the overpayment;

(e) the health insurance claim number, as appropriate;

(f) the date(s) of service;
(g) the medicaid claim control number, as appropriate;
(h) the description of a corrective action plan to ensure the overpayment does not occur again;
(i) whether the provider has a corporate integrity agreement (CIA) with the United States department of health and human services (HHS) office of inspector general (OIG) or is under the HHS/OIG self-disclosure protocol;
(j) the specific dates (or time span) within which the problem existed that caused the overpayments;
(k) whether a statistical sample was used to determine the overpayment amount and, if so, a description of the statistically valid methodology used to determine the overpayment; and
(l) the refund amount;

(4) The MCO shall notify its providers of the provision that overpayments identified by a provider but not self-reported by a provider within the 60-day timeframe are presumed to be false claims and are subject to referrals as credible allegations of fraud;

(5) The MCO shall report claims identified for overpayment recovery:
(a) in a format requested by HSD; and
(b) make 837 encounter adjustments with an identifier specified by HSD for recoveries identified by a governmental entity or its designee.

(6) Provide all records pertaining to overpayment recovery efforts as requested by HSD.

D. Refunds of overpayments:

(1) All self-reported refunds for overpayments shall be made by the provider to his or her MCO and are property of the MCO, unless:
(a) a governmental entity or its designee independently notified the provider that an overpayment existed; or
(b) the MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim;
(c) the MCO fails to complete the recovery within 15 months from the date it first paid the claim; or
(d) provisions in the HSD agreement with the MCO otherwise provide for all or part of the recovery to go to MAD or HSD.

(2) In situations where the MCO and a governmental entity, or its designee, jointly audit its provider, the MCO and the governmental entity or designee shall agree upon a distribution of any refund.

(3) Unless otherwise agreed to by the MCO and HSD, the MCO shall not be entitled to any refund or recovery if the refund or recovery is part of a resolution of a state or federal investigation, lawsuit, including but not limited to False Claims Act cases.

D. Member fraud, abuse and overutilization:

(1) cases involving one or more of the following situations constitute sufficient grounds for a member fraud referral:
(a) the misrepresentation of facts in order to become or to remain eligible to receive benefits under New Mexico medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined;
(b) the transferring by a member of a medicaid member identification (ID) card to a person not eligible to receive services under New Mexico medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits; and
(c) the unauthorized use of a medicaid member ID card by a person not eligible to receive medical benefits under a medical assistance program or is a high utilizer of services without apparent medical justification.

(2) HSD and the MCO shall possess the authority to restrict or lock-in a member to a specified and limited number of providers if he or she is involved in potential fraudulent activities or is identified as abusing services provided under his or her medicaid program.
(a) Prior to placing a member on a provider lock-in, the MCO shall inform him or her of the intent to lock-in, including the reasons for imposing the provider lock-in.
(b) The restriction does not apply to emergency services furnished to this member.
(c) The MCO's grievance procedure shall be made available to the member disagreeing with the provider lock-in.

(d) The member shall be removed from provider lock-in when his or her MCO has determined that the member's utilization problems or detrimental behavior has ceased and that recurrence of the problems is judged to be improbable.

(e) HSD shall be notified of provider lock-ins and provider lock-in removals.

[8.308.22.9 NMAC - N, 1-1-14]

History of 8.308.22 NMAC:

MEDICAID MANAGED CARE
PROVIDER NETWORK

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 2 PROVIDER NETWORK

8.308.2.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.2.1 NMAC - N, 1-1-14]

8.308.2.2 SCOPE: This rule applies to the general public.
[8.308.2.2 NMAC - N, 1-1-14]

8.308.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.2.3 NMAC - N, 1-1-14]

8.308.2.4 DURATION: Permanent.
[8.308.2.4 NMAC - N, 1-1-14]

8.308.2.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.2.5 NMAC - N, 1-1-14]

8.308.2.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.2.6 NMAC - N, 1-1-14]

8.308.2.7 DEFINITIONS: [RESERVED]
[8.308.2.7 NMAC - N, 1-1-14]

8.308.2.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.2.8 NMAC - N, 1-1-14]

8.308.2.9 GENERAL REQUIREMENTS: The HSD medicaid managed care organization (MCO) shall establish and maintain a comprehensive network of providers and required specialists in sufficient numbers to make all services included in the benefit package available in accordance with access standards. The MCO shall require any contracted provider to be enrolled with HSD's medical assistance division (MAD) as a managed care provider; and refer any provider who notifies the MCO of a change in his or her location, licensure, certification, or status to the MAD provider web portal to update his or her provider information.

A. Required MCO policies and procedures:

(1) Pursuant to section 1932(b)(7) of the Social Security Act, the MCO shall not discriminate against a provider that serves high-risk populations or specializes in conditions that require costly treatment.

(2) The MCO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider acting within the scope of his or her provider's license or certification under applicable state statute or rule solely on the basis of the provider's license or certification.

(3) The MCO shall upon declining to include an individual or a group of providers in its network, give the affected provider written notice of the reason for the MCO decision.

(4) The MCO shall conduct screenings of all subcontractors and contract providers in accordance with the Employee Abuse Registry Act, NMSA 1978 27-7A-3, the New Mexico Caregivers Criminal History Screening Act, NMSA 1978, 2-17-2 et seq. and NMAC 7.1.9, the New Mexico Children's and Juvenile Facility Criminal Records Screening Act, NMSA 1978 32A-15-1 to 32A-15-4, Patient Protection and Affordable Care Act (PPACA), and ensure that all subcontracted and contracted providers are screened against the New Mexico "list of excluded individuals or entities" and the medicare exclusion databases.

(5) The MCO shall require that any provider, including a provider making a referral or ordering a covered service, have a national provider identifier (NPI) unless the provider is an atypical provider as defined by the centers for medicare and medicaid services (CMS).

(6) The MCO shall require that each provider billing for or rendering services to a MCO member has a unique identifier in accordance with the provisions of section 1173(b) of the Social Security Act.

(7) The MCO shall consider in establishing and maintaining the network of appropriate providers its:

(a) anticipated enrollment;

(b) numbers of contracted providers who are not accepting new patients; and

(c) geographic locations of contracted providers and members, considering distance, travel time, the means of transportation ordinarily used by members; and whether the location provides physical access for members with disabilities.

(8) The MCO shall ensure that a contracted provider offers hours of operation that are no less than the hours of operation offered to its commercial enrollees.

(9) The MCO shall establish mechanisms such as notices or training materials to ensure that a contracted provider comply with the timely access requirements, monitor such compliance regularly, and take corrective action if there is a failure to comply.

(10) The MCO shall provide to its members and contracted providers clear instructions on how to access covered services, including those that require prior approval and referral.

(11) The MCO shall ensure that all contracted providers meet all availability; time and distance standards set by HSD, and have a system to track and report this data.

(12) The MCO shall provide access to a non-contracted provider if the MCO is unable to provide covered benefits covered under its agreement with HSD in an adequate and timely manner to a member and continue to authorize the use of a non-contracted provider for as long as the MCO is unable to provide these services through its contracted providers. The MCO must ensure that the cost to its members utilizing a non-contracted provider is not greater than it would be if the service was provided within the MCO's network.

B. Health services contracting: Contracts with an individual and an institutional provider shall mandate compliance with the MCOs quality management (QM) and quality improvement (QI) programs.

C. Provider qualifications and credentialing: The MCO shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO meets applicable federal and state requirements for licensing, certification, accreditation and re-credentialing for the type of care or services within the scope of practice as defined by federal and state statutes, regulations, and rules.

D. Utilization of out-of-state providers: To the extent possible, the MCO is encouraged to utilize in-state and border providers, which are defined as those providers located within 100 miles of the New Mexico border, Mexico excluded. The MCO may include out-of-state providers in its network.

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

F. Pharmacy lock-in: HSD shall allow the MCO to require that its member see a certain pharmacy provider when the member's compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member of the intent to lock-in. The MCO's grievance procedure shall be made available to a member being designated for pharmacy lock-in. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all provider lock-ins and provider lock-in removals at the time they occur as well as receiving existing lock-in information on a quarterly basis.

[8.308.2.9 NMAC - N, 1-1-14]

8.308.2.10 PRIMARY CARE PROVIDER (PCP): The MCO shall ensure that each member is assigned a primary care provider (PCP), except a member that is dually eligible for medicare and medicaid (dual eligible). The PCP shall be a provider identified in Section A below, participating in the MCO's network who will assume the responsibility for supervising, coordinating, and providing primary health care to its member, initiating referrals for specialist care, and maintaining the continuity of the member's care. For a dual-eligible member, the MCO will be

responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's medicare PCP.

A. Types of PCPs: The MCO shall designate the following types of providers as a PCP as appropriate:

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

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

(3) specialists, on an individual basis, for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness, complex behavioral health conditions, or disabilities;

(4) a primary care team consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that include mid-level practitioners who, at the member's request, may serve as the point of first contact. In both instances the MCO shall organize its team to ensure continuity of care to the member and shall identify a "lead physician" within the team for each member. The "lead physician" shall be an attending physician. Medical students, interns and residents may not serve as "lead physicians";

(5) federally qualified health centers (FQHC), rural health clinics (RHC), or Indian health service (IHS), tribal health providers, and urban Indian providers (I/T/U); or

(6) other providers that meet the credentialing requirements for PCPs.

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

(1) Initial enrollment: At the time of enrollment, the MCO shall ensure that each member has the freedom to choose a PCP within a reasonable distance from his or her place of residence.

(2) Subsequent change in PCP initiated by a member: the MCO shall allow its member to change his or her PCP at any time for any reason. The request can be made in writing or verbally via telephone:

(a) if a request is made on or before the 20th calendar day of the month, the change shall be effective as the first of the following month.

(b) if a request is made after the 20th calendar day of the month, the change shall be effective the first calendar day of the second month following the request.

(3) A subsequent change in PCP initiated by the MCO: The MCO may initiate a PCP change for its member under the following circumstances:

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

(b) a member's PCP ceases to be a contracted provider;

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

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

(e) the PCP is suspended for any reason.

(4) The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each member who received his or her primary care from or was seen on a regular basis by the terminated provider. In such instances, the MCO shall allow affected members to select a PCP or the MCO shall make an assignment within 15 calendar days of the termination effective date.

[8.308.2.10 NMAC - N, 1-1-14]

8.308.2.11 STANDARDS FOR ACCESS: The MCO shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service to its members. The MCO shall provide access to the full array of covered services within the benefit package. If a service is unavailable based on the access guidelines, a service equal to or higher than that service shall be offered.

A. Access to urgent and emergency services: Services for emergency conditions provided by physical and behavioral health providers, including emergency transportation, urgent conditions, and post-stabilization care shall be covered by the MCO (only within the United States for both physical and behavioral health). An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for child and adolescent members or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs

that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health treatment, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. Post-stabilization care means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The MCO shall ensure that there is no clinically significant delay caused by the MCO's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO's network, and all emergency services shall be reimbursed at the HSD approved rate. The MCO shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergent in nature.

(2) The MCO shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency care, regardless of whether the provider is contracted with the MCO.

(3) The MCO shall ensure that the member has access to the nearest appropriately designated trauma center according to established emergency medical standards (EMS) triage and transportation protocols.

B. PCP availability: the MCO shall follow a process that ensures a sufficient number of PCPs are available to allow members a reasonable choice among providers.

(1) The MCO shall have at least one PCP available per 2,000 members and not more than 2,000 members are assigned to a single provider unless approved by HSD.

(2) The MCO must ensure that members have adequate access to specialty providers.

(3) The minimum number of PCPs from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. Urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana. Frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola. Rural counties are those that are not urban or frontier. The standards are as follows:

(a) 90 percent of urban member residents shall travel no farther than 30 miles;

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

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

C. Pharmacy provider availability: The MCO shall ensure that a sufficient number of pharmacy providers are available to its members. The MCO shall ensure that pharmacy services meet geographic access standards based on its member's county of residence. The access standards are as follows:

(a) 90 percent of urban residents shall travel no farther than 30 miles;

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

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

[8.308.2.11 NMAC - N, 1-1-14]

8.308.2.12 ACCESS TO HEALTH CARE SERVICES: The MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice, and ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

A. The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in its network that are not accepting new MCO members.

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

C. For routine asymptomatic member-initiated dental appointments the request-to-appointment time shall be consistent with community norms for dental appointments.

D. For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

E. For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time.

F. Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

G. For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in Subection E of this section, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time.

H. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 calendar days, unless the member requests a later time.

I. For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

J. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

K. The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

L. The MCO shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

M. The MCO's preferred drug list (PDL) shall follow HSD guidelines for services and items included in the managed care benefit package, pharmacy services.

N. Access to durable medical equipment: The MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(1) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 calendar days of the request date.

(2) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(3) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(4) All DME repairs or non-customized modifications shall be delivered within 60 calendar days of the request date.

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

(6) The MCO shall ensure that its member and his or her family or caretaker receive proper instruction on the use of DME provided by the MCO or its subcontractor.

O. Access to prescribed medical supplies: The MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The MCO shall ensure that:

(1) a member can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(2) a member can access routine medical supplies within a time frame consistent with the clinical need;

(3) subject to any requirements to procure a PCP order to provide supplies to its members, members utilizing medical supplies on an ongoing basis shall submit to the MCO lists of needed supplies monthly; and the MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(4) The MCO shall ensure that its member and his or her family receive proper instruction on the use of medical supplies provided by the MCO or its subcontractors.

P. Access to transportation services: The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall have sufficient transportation providers available to meet the needs of its members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependent or have other equipment needs. The MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minor aged members are accompanied by a parent or legal guardian as indicated to provide safe transportation.

Q. Use of technology: The MCO is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.
[8.308.2.12 NMAC - N, 1-1-14]

8.308.2.13 SPECIALTY PROVIDERS: The MCO shall contract with a sufficient number of specialists with the applicable range of expertise to ensure that the needs of the members are met within the MCO's provider network. The MCO shall also have a system to refer members to non-contracted providers if providers with the necessary qualifications or certifications do not participate in the network. Out-of-network providers must coordinate with the MCO with respect to payment. The MCO must ensure that cost to its member is no greater than it would be if the services were furnished within the network.
[8.308.2.13 NMAC - N, 1-1-14]

8.308.2.14 FAMILY PLANNING PROVIDERS:

A. The MCO shall give each adolescent and adult member the opportunity to use his or her own PCP or to use any family planning provider for family planning services without requiring a referral. Each female member shall also have the right to self-refer to a contracted women's health specialist for covered services necessary to provide women's routine and preventive health services. This right to self-refer is in addition to the member's designated source of primary care if that source is not a women's health specialist. Family planning providers, including those funded by Title X of the public health service, shall be reimbursed by the MCO for all covered family planning services, regardless of whether they are contracted providers of the member's MCO. Unless otherwise negotiated, the MCO shall reimburse providers of family planning services pursuant to the medicaid fee schedule.

B. Pursuant to state statute and rule, a non-contracted provider is responsible for keeping family planning information confidential in favor of the individual member even if the member is a minor. The MCO is not responsible for the confidentiality of medical records maintained by a non-contracted provider, but shall notify the non-contracted provider of the confidentiality provisions contained herein.
[8.308.2.14 NMAC - N, 1-1-14]

8.308.2.15 STANDARDS FOR CREDENTIALING AND RE-CREDENTIALING: The MCO shall document the mechanism for credentialing and re-credentialing of a provider with whom it contracts or employs to treat its members outside the inpatient setting and who fall under its scope of authority. The documentation shall include, but not be limited to, defining the provider's scope of practice, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or re-credentialing arrangements. The credentialing process shall be completed within 45 calendar days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCO shall use the HSD approved primary source verification entity or one entity for the collection and storage of provider credentialing application information unless there are more cost effective alternatives approved by HSD.

A. Practitioner participation: The MCO shall have a process for receiving input from participating providers regarding credentialing and re-credentialing of its providers.

B. Primary source verification: The MCO shall verify the following information from primary sources during its credentialing process:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the practitioner as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of practitioner including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the practitioner;

(5) board certification if the practitioner states on the application that he or she is board certified in a specialty;

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

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

C. Credentialing application: The MCO shall use the HSD approved credentialing form. The provider shall complete a credentialing application that includes a statement by him or her regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;
(2) lack of present illegal drug use;
(3) history of loss of license and felony convictions;
(4) history of loss or limitation of privileges or disciplinary activity;
(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and
(6) applicant attests to the correctness and completeness of the application.

D. External source verification: Before a practitioner is credentialed, the MCO shall receive information on the practitioner from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the practitioner type;
(2) information about sanctions or limitations on licensure from the following agencies, as applicable:
(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;
(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;
(c) state board of dental examiners;
(d) state board of podiatric examiners;
(e) state board of nursing;
(f) the appropriate state licensing board for other practitioner types, including behavioral health; and
(g) other recognized monitoring organizations appropriate to the practitioner's discipline.
(3) a Health and Human Services (HHS)/Office of Inspector General (OIG) exclusion from participation on medicare, medicaid, the state children's health insurance plan (SCHIP), and all federal health care programs (as defined in section 1128B(f) of the Social Security Act), and sanctions by medicare, medicaid, SCHIP or any federal health care program.

E. Evaluation of practitioner site and medical records: The MCO shall perform an initial visit to the offices of a potential PCP, obstetrician, and gynecologist, and shall perform an initial visit to the offices of a potential high volume behavioral health care practitioner prior to acceptance and inclusion as a contracted provider. The MCO shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the HSD managed care contract.
(2) The MCO shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO's organizational standards.

F. Re-credentialing: The MCO shall have formalized re-credentialing procedures.

(1) The MCO shall re-credential its providers at least every three years. The MCO shall verify the following information from primary sources during re-credentialing:
(a) a current valid license to practice;
(b) the status of clinical privileges at the hospital designated by the practitioner as the primary admitting facility;
(c) valid DEA or CSR certificate, if applicable;
(d) board certification, if the practitioner was due to be recertified or became board certified since last credentialed or re-credentialed;
(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the practitioner; and
(f) a current signed attestation statement by the applicant regarding:
(i) ability to perform the essential functions of the position, with or without accommodation;
(ii) lack of current illegal drug use;
(iii) history of loss or limitation of privileges or disciplinary action; and
(iv) current professional malpractice insurance coverage.
(2) There shall be evidence that, before making a re-credentialing decision, the MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:
(a) the national practitioner data bank;
(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other provider types;

(i) other recognized monitoring organizations appropriate to the provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, SCHIP and all federal health care programs.

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

(a) member grievances and appeals;

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

(c) medical record reviews conducted under Subsection E this section.

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

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

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

H. Assessment of organizational providers: The MCO shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. At least every three years, the MCO shall:

(1) confirm that the provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following;

(a) the department of health (DOH) is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) the children, youth and families department (CYFD) is the certification agency for child and adolescent behavioral health organizational services and providers that require certification; and

(2) confirm that the provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission (JC); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.308.2.15 NMAC - N, 1-1-14]

8.308.2.16 PROVIDER TRANSITION: The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that would have a negative effect on member access to services or on the MCOs ability to deliver services included in the benefit package. Anticipated material changes in the MCO provider network shall be reported in writing within 30 calendar days prior to the change or as soon as the MCO becomes aware of the anticipated change. In the event that provider network changes are unexpected or when it is determined that its provider is unable to meet its contractual obligation, the MCO shall be required to submit a transition plan to HSD for all affected members. For all provider transitions, the MCO shall require the provider to submit a member specific transition plan. For both expected and unexpected changes in the network, the MCO shall be required to assess the significance of the change or closure to the network and shall submit a narrative as part of the notification of the closure within timeframes designated, and in a template approved by, the state as detailed in the HSD policy manual.

[8.308.2.16 NMAC - N, 1-1-14]

8.308.2.17 DELEGATION: Delegation is a process whereby a MCO gives another entity the authority to perform certain functions on its behalf. The MCO is fully accountable for all pre-delegation and delegation activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO may assign, transfer, or delegate to a subcontractor key management functions with the explicit written approval of HSD.

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

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

(2) the delegated activity;

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

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

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

B. The MCO shall document evidence that it:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively indentifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the MCO expectations and HSD's standards.

[8.308.2.17 NMAC - N, 1-1-14]

HISTORY OF 8.308.2 NMAC: [RESERVED]

MANAGED CARE PROGRAM
ELIGIBILITY AND ENROLLMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 6 ELIGIBILITY AND ENROLLMENT

8.308.6.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.6.1 NMAC - N, 1-1-14]

8.308.6.2 SCOPE: This rule applies to the general public.
[8.308.6.2 NMAC - N, 1-1-14]

8.308.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.6.3 NMAC - N, 1-1-14]

8.308.6.4 DURATION: Permanent.
[8.308.6.4 NMAC - N, 1-1-14]

8.308.6.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.6.5 NMAC - N, 1-1-14]

8.308.6.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.6.6 NMAC - N, 1-1-14]

8.308.6.7 DEFINITIONS: [RESERVED].
[8.308.6.7 NMAC - N, 1-1-14]

8.308.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.6.8 NMAC - N, 1-1-14]

8.308.6.9 MANAGED CARE ELIGIBILITY:

A. General Requirements: HSD determines eligibility for enrollment in the medical assistance division (MAD) managed care program. An eligible recipient is required to participate in a HSD managed care program unless specifically excluded as listed below. Enrollment in a particular MCO will be according to the eligible recipient's selection of a MCO at the time of application for eligibility during other permitted selection periods or as assigned by HSD.

B. The following eligible recipients are excluded from managed care enrollment:

(1) qualified medicare beneficiaries(QMB)-only recipients;
(2) specified low income medicare beneficiaries;
(3) qualified individuals;
(4) qualified disabled working individuals;
(5) refugees;
(6) participants in the program of all inclusive care for the elderly (PACE); and
(7) children and adolescents in out-of-state foster care or adoption placements; and

C. A native American who doesn't meet a nursing facility (NF) or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) levels of care (LOC) or is not dually-eligible for both medicaid and medicare is not enrolled in a HSD managed care program unless the eligible recipient elects to enroll.

D. HSD or its authorized agent may further determine eligibility for HSD managed care through an allocation process contingent upon available funding and enrollment capacity.
[8.308.6.9 NMAC - N, 1-1-14]

8.308.6.10 SPECIAL SITUATIONS:

A. HSD has established newborn eligibility criteria.

(1) When a child is born to a member enrolled in a MCO, the hospital or other providers will complete a MAD Form 313 (*Notification of Birth*) or its successor, prior to or at the time of discharge. HSD shall ensure that upon receipt of the MAD Form 313 and upon completion of the eligibility process, the newborn is enrolled into his or her mother's MCO. The newborn is eligible for a period of 12 months, starting with the month of his or her birth.

(3) The newborn whose mother is covered by health insurance through the New Mexico health insurance exchange and the mother's qualified health plan is also a MCO; the newborn shall be enrolled as of the month of birth into the mother's MCO.

(4) The newborn member whose mother is covered by health insurance through New Mexico health insurance exchange and the mother's qualified health plan is not a MCO; the newborn shall be auto-assigned and enrolled in a MCO as of the month of his or her birth. The newborn member's parent or legal guardian will have one opportunity during the 90 calendar day period from the effective date of enrollment to change the newborn's MCO assignment.

B. Community benefit eligibility:

(1) A member who meets a NF LOC and is eligible for the community benefit will be eligible to receive home and community-based services and may choose to receive such services either through an agency-based or self-directed model according to the self-direction criteria as outlined in 8.308.9 NMAC.

(2) An individual who is not otherwise eligible for medicaid services but meets certain financial requirements and has a NF LOC determination may be eligible for enrollment under the MAD community benefit plan. A member's community benefit plan enrollment is through an allocation process, contingent upon funding and enrollment capacity.

[8.308.6.10 NMAC - N, 1-1-14]

HISTORY OF 8.308.6 NMAC: [RESERVED]

MANAGED CARE PROGRAM
ENROLLMENT AND DISENROLLMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 308 CENTENNIAL CARE MANAGED CARE
PART 7 ENROLLMENT AND DISENROLLMENT

8.308.7.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.7.1 NMAC - N, 1-1-14]

8.308.7.2 SCOPE: This rule applies to the general public.
[8.308.7.1 NMAC - N, 1-1-14]

8.308.7.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.7.3 NMAC - N, 1-1-14]

8.308.7.4 DURATION: Permanent.
[8.308.7.4 NMAC - N, 1-1-14]

8.308.7.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.7.5 NMAC - N, 1-1-14]

8.308.7.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.7.6 NMAC - N, 1-1-14]

8.308.7.7 DEFINITIONS: [RESERVED].
[8.308.7.7 NMAC - N, 1-1-14]

8.308.7.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.7.8 NMAC - N, 1-1-14]

8.308.7.9 MANAGED CARE ENROLLMENT

A. **General:** A medical assistance division (MAD) eligible recipient is required to enroll in a HSD managed care organization (MCO) unless he or she is: (1) a Native American and elects enrollment in MAD's fee-for-service (FFS); or (2) is in an excluded population. See 8.200.410. Enrollment in a MCO may be the result of the eligible recipient's selection of a particular MCO or assigned by HSD. The MCO shall accept as a member an eligible recipient in accordance with 42 CFR 434.25 and shall not discriminate against, or use any policy or practice that has the effect of discrimination against the potential or enrolled member on the basis of health status, the need for health care services, or the race, color, national origin, ancestry, spousal affiliation, sexual orientation or gender identity. HSD reserves the right to limit enrollment in a specific MCO.

B. **Newly eligible recipients:** An individual who applies for a MAD category of eligibility and has an approved eligibility effective date of January 1, 2014, or later, and who is required to enroll in a MCO, must select a MCO at the time of his or her application for a MAD category of eligibility. An eligible recipient who fails to select a MCO at such time will be assigned to a MCO. See section 9, subsection C of 8.308.7. NMAC, *Enrollment and Disenrollment*.

C. **Auto Assignment:** HSD will auto assign an eligible recipient to a MCO in specific circumstances, including but not limited to: (a) the eligible recipient is not exempt from managed care and does not select a MCO at the time of his or her application for MAD eligibility; (b) the eligible recipient cannot be enrolled in the requested MCO pursuant to the terms of this rule (e.g., the MCO is subject to and has reached its enrollment limit). HSD may modify the auto assignment algorithm, at its discretion when it determines it is in the best interest of the program, including but not limited to, incorporating quality measures, and cost or utilization management performance criteria.

(1) The HSD auto assignment process will consider the following:

(a) if the eligible recipient was previously enrolled with a MCO and lost his or her eligibility for a period of two months or less, may be re-enrolled with that MCO;

(b) if the eligible recipient has a family member enrolled in a specific MCO, he or she will be enrolled with that MCO;

(3) if the eligible recipient is a newborn, he or she will be assigned to the mother's MCO. See section 10, subsection A of 8.100.2 NMAC; or

(4) if none of the above applies, the eligible recipient will be assigned using the default logic that randomly assigns an eligible recipient to a MCO.

D. **Effective date for a newly eligible recipient's enrollment with a MCO:**

(1) The effective date of enrollment with a MCO will be the same as the effective date of the eligible recipient's MAD enrollment approval. In instances of an award of retroactive MAD eligibility, the effective date of enrollment of the eligible recipient with a MCO does not include time periods prior to January 1, 2014.

(2) At HSD's discretion, the effective date of enrollment for a newly eligible recipient may be modified at any time.

E. **Eligible recipient member lock-in:** A member's enrollment with a MCO is for a 12-month lock-in period. During the first 90 calendar days after his or her initial MCO enrollment, either by the member's choice or by auto assignment, he or she shall have one option to change MCOs for any reason, except as described below.

(1) If the member does not choose a different MCO during his or her first 90 calendar days, the member will remain with this MCO for the full 12-month lock-in period before being able to switch MCOs.

(2) If during the member's first 90 calendar days of enrollment in the initially-selected or a HSD assigned MCO, and chooses a different MCO, he or she is subject to a new 12-month lock-in period and will remain with the newly selected MCO until the lock-in period ends. After that time, the member may switch to another MCO.

(3) At the conclusion of the 12-month lock-in period, the member shall have the option to select a new MCO, if desired. The member shall be notified of the option to switch MCOs 60 days prior to the expiration date of the member's lock-in period, the deadline by when to choose a new MCO.

(4) If a member loses his or her MAD eligibility for a period of two months or less, he or she will be automatically reenrolled with the former MCO. If the member misses what would have been his or her annual switch MCO enrollment period during this two-month period, he or she may select another MCO.

F. **Open MCO enrollment period:** Open enrollment periods are when a member can change his or her MCO without having to wait until the end of the 12 month lock-in period, may be initiated at HSD's discretion in order to support program needs.

G. **Mass transfers from another MCO:** A MCO shall accept any member transferring from another MCO as authorized by HSD. The transfer of membership may occur at any time during the year.

H. **Change of enrollment initiated by a member:**

(1) A member may select another MCO during his or her annual switch MCO enrollment period.

(2) A member may request to be switched to another MCO for cause, even during a lock-in period. The member must submit a written request to HSD. Examples of "*cause*" include, but are not limited to:

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

(b) the member requires related services (for example a cesarean section and a tubal ligation) to be performed at the same time, not all of the related services are available within the network, and his or her PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(c) poor quality of care, lack of access to covered benefits, or lack of access to providers experienced in dealing with the member's health care needs.

(3) No later than the first calendar day of the second month following the month in which the request is filed by the member, HSD must respond. If HSD does not respond, the request of the member is deemed approved. If the member is dissatisfied with HSD's determination, he or she may request a HSD administrative hearing.

[8.308.7.9 NMAC - N, 1-1-14]

8.308.7.10 DISENROLLMENT

A. **Member disenrollment initiated by a MCO:** The MCO shall not, under any circumstances, disenroll a member. The MCO shall not request disenrollment because of a change in the member's health status, because of the his or her utilization of medical or behavioral health services, his or her diminished mental capacity,

or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either a particular member or other members).

B. **Other HSD member disenrollment:** A member may be disenrolled from a MCO or may lose his or her MAD eligibility if:

(1) he or she moves out of the state of New Mexico;

(2) he or she no longer qualifies for a MAD category of eligibility;

(3) he or she requests disenrollment for cause, including but not limited to the unavailability of a specific care requirement that none of the contracted MCOs are able to deliver and disenrollment is approved by HSD;

(4) a member makes a request for disenrollment which is denied by HSD, but the denial is overturned in the member's HSD administrative hearing final decision; or

(5) HSD imposes a sanction on the MCO that warranted disenrollment.

C. **Effective Date of Disenrollment:** All HSD-approved disenrollment requests are effective on the first calendar day of the month following the month of the request for disenrollment, unless otherwise indicated by HSD. In all instances, the effective date shall be indicated on the termination record sent by HSD to the MCO.
[8.308.7.9 NMAC - N, 1-1-14]

8.308.7.10 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is in the best interests of the program.

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

(1) a maintenance change, such as changes in the MCO identification number or the MCO changes its name or other changes that is not relevant to the member and services will continue with that MCO; and

(2) a significant change in a MCO's contracting status, including but not limited to, the loss of licensure, substandard care, fiscal insolvency or significant loss in network providers. In such instances, a notice is sent to the member informing his or her of the transfer and the opportunity to select a different MCO.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.
[8.308.7.10 NMAC - N, 1-1-14]

8.308.7.11 MEMBER IDENTIFICATION CARD

A. Each member shall receive an identification card (ID) that provides his or her MCO membership information within 30 calendar days of notification of enrollment with the MCO.

B. The MCO shall re-issue a member ID card within 10 calendar days of notice if the member reports a lost card or if information on the card needs to be changed.

C. The MCO shall ensure a member understands that the ID card: (1) is intended to be used only by the member; (2) the sharing the member's ID card constitutes fraud; and (3) the process of how to report sharing of a member's ID card.
[8.308.7.11 NMAC - N, 1-1-14]

8.308.7.12 MEDICAID MARKETING GUIDELINES: HSD shall review and approve the content, comprehension level, and language(s) of all marketing materials directed at a member before use by a MCO. The MCO shall comply with all federal regulations regarding medicare-advantage and medicaid marketing. See 42 C.F.R. Parts 422, 438.
[8.308.7.12 NMAC - N, 1-1-14]

HISTORY OF 8.3080.7 NMAC:
[RESERVED]

MANAGED CARE PROGRAM
MEMBER EDUCATION, RIGHTS AND RESPONSIBILITIES

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 8 MEMBER EDUCATION, RIGHTS AND RESPONSIBILITIES

8.308.8.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.8.1 NMAC - N, 1-1-14]

8.308.8.2 SCOPE: This rule applies to the general public.
[8.308.8.2 NMAC - N, 1-1-14]

8.308.8.3 STATUTORY AGENCY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended by state statute. See NMAS 1978, Section 27-1-12 et seq.
[8.308.8.4 NMAC - N, 1-1-14]

8.308.8.4 DURATION: Permanent.
[8.308.8.4 NMAC - N, 1-1-14]

8.308.8.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.8.5 NMAC - N, 1-1-14]

8.308.8.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.8.6 NMAC - N, 1-1-14]

8.308.8.7 DEFINITIONS: [RESERVED].
[8.308.8.7 NMAC - N, 1-1-14]

8.308.8.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.8.8 NMAC - N, 1-1-14]

8.308.8.9 MEMBER EDUCATION: A member of a medical assistance division (MAD) manage care organization (MCO) shall be educated about his or her rights and responsibilities, covered services and service availability under a HSD MCO. Member education is initiated when an eligible recipient becomes a MCO member and includes information provided by HSD and the MCO.
[8.308.8.9 NMAC - N, 1-1-14]

8.308.8.10 WRITTEN MEMBER MATERIALS:

A. All written materials will be available in English and all languages spoken by approximately five percent or more of the population. Upon consent from the appropriate Native American tribal leadership, the MCO shall make every effort when a written form is not in the member's native language to translate the form in the member's native language.

B. The MCO is responsible for providing a member and a potential member with its member handbook or provider directory, and if available, both.

(1) The MCO shall send such information to the member within 30 calendar days of receipt of notification of enrollment in the MCO.

(2) Thereafter, upon the request from a member, the MCO shall send such information within 10 calendar days. The MCO shall provide the requestor the option to receive the material in a written or electronic form or by citation to be found on the member's MCO's website.

(3) On an annual basis, the MCO shall notify the member of the availability of updated materials and how to obtain such materials.
[8.308.8.10 NMAC - N, 1-1-14]

8.308.8.11 MEMBER RIGHTS AND RESPONSIBILITIES:

A. Included in its membership information, the MCO shall provide each member written information on his, her or the authorized representative rights and responsibilities.

B. These include the right:

(1) to be treated with respect and with due consideration for his or her dignity and privacy;

(2) to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand such information;

(3) to make and have honored his or her advance directive that is consistent with state and federal laws;

(4) to receive MCO covered services in a nondiscriminatory manner;

(5) to participate in decisions regarding his or her health care, including the right to refuse treatment;

(6) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

(7) to request and receive a free copy of his or her medical records and to request that those records be amended or corrected. See [45 CFR164];

(8) to choose an authorized representative to be involved, as appropriate, in making his or her care decisions;

(9) to provide informed consent;

(10) to voice a grievance concerning the care provided by his or her MCO, and to make use of his or her grievance and appeal process, and his or her HSD administrative hearing process without fear of retaliation;

(11) to choose from among contracted providers in accordance with his or her MCO's prior authorization requirements;

(12) to receive information about covered services and how to access these covered services, and contracted providers;

(13) to be free from harassment by the MCO or its contracted providers in regard to contractual disputes between the MCO and the provider; and

(14) participate in understanding physical an behavioral health problems and developing mutually agreed-upon treatment goals.

C. The MCO shall ensure that each member or his or her authorized representative is free to exercise his or her rights, and the exercise of those rights does not adversely affect the way that the MCO or its contracted provider treat the member or his or her authorized representative.

D. The member or his or her authorized representative, to the extent possible, has a responsibility:

(1) to provide information that the MCO and its contracted providers need in order to care for the member, such information includes, but is not limited to the member's:

(a) most current mailing address;

(b) most current email address, if one is available;

(c) most current phone number, including any land line and cell phone, if one is available; and

(d) most current emergency contact information;

(2) to follow the care plans and instructions from his or her provider that have been agreed upon;

(3) to keep a scheduled appointment; and

(4) to reschedule or cancel a scheduled appointment rather than simply fail to keep it.

[8.308.8.11 NMAC - N, 1-1-14]

8.308.8.12 MEMBER HEALTH RECORDS: The MCO shall provide a member with access to electronic versions of his or her personal health records.
[8.308.8.12 NMAC – N, 1-1-14]

8.308.8.13 MEMBER HEALTH EDUCATION:

A. The MCO shall develop a member health education plan that includes classes, individual or group sessions, videotapes, written materials, media campaigns and modern technologies (e.g. mobile applications and tools).

(1) All instructional materials shall be provided in a manner and format that is easily understood by a member.

(2) The MCO shall notify a member of the schedule of educational events and shall post such information on its website.

B. The MCO shall distribute a quarterly newsletter that is intended to educate members about the managed care system, the proper utilization of services, and to encourage utilization of preventative care services.

[8.308.8.13 NMAC - N, 1-1-14]

8.308.8.14 MEMBER WEBSITE: The MCO shall have a member portal on its website that is available to all members, and contains accurate, up-to-date information about the MCO, services provided, the preferred drug list, the provider directory, frequently asked questions (FAQs), and contact phone numbers and its email addresses. A member shall have access to the member handbook and provider directory via the website without having to log-in.
[8.308.8.14 NMAC - N, 1-1-14]

8.308.8.15 MEMBER TOLL-FREE LINE: The MCO shall operate a call center with a toll-free phone line to respond to member questions, concerns, inquiries and complaints from a member and his or her provider. The line shall be equipped to handle calls from an individual with limited English proficiency, as well as calls from a member who is hearing impaired. It should be staffed 24 hours a day, seven days a week, with qualified nurses to triage urgent care and emergency calls from a member, and when necessary, to facilitate the transfer of such calls to a care coordinator.
[8.308.8.15 NMAC - N, 1-1-14]

8.308.8.16 MEMBER ADVISORY BOARD: The MCO shall convene an advisory board of that meets quarterly and reflects appropriate representation of its membership. The advisory board shall advise the MCO on issues concerning service delivery, quality of its covered services, and other member issues as needed or as directed by HSD.
[8.308.8.16 NMAC - N, 1-1-14]

HISTORY OF 8.308.x NMAC:
[RESERVED]

MANAGED CARE PROGRAM
CARE COORDINATION

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 10 CARE COORDINATION

8.308.10.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.10.1 NMAC – N, 1-1-14]

8.308.10.2 SCOPE: This rule applies to the general public.
[8.308.10.2 NMAC – N, 1-1-14]

8.308.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.10.3 NMAC – N, 1-1-14]

8.308.10.4 DURATION: Permanent.
[8.308.10.4 NMAC – N, 1-1-14]

8.308.10.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.10.5 NMAC – N, 1-1-14]

8.308.10.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.10.6 NMAC – N, 1-1-14]

8.308.10.7 DEFINITIONS: [RESERVED]
[8.308.10.7 NMAC – N, 1-1-14]

8.308.10.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.10.8 NMAC – N, 1-1-14]

8.308.10.9 CARE COORDINATION:
A. **General Requirements**
(1) Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers ; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care.
(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, MCO will document the refusal in the member's file and reported to HSD.
(3) If a Native American member requests assignment to a Native American care coordinator and the MCO is unable to provide a Native American care coordinator to such member, the MCO must ensure that a mutually-agreed upon community health worker is present for all in–person meetings between the care coordinator and the member.
(4) Individuals with special health care needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other members. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.
B. **Health Risk Assessment (HRA)**:
(1) Within 10 calendar days of the member's enrollment with a MCO, the MCO shall conduct a

health risk assessment (HRA) either by telephone or in person. The HRA is conducted for the purpose of: (1) introducing the MCO to the member; (2) obtaining basic health and demographic information about (3) assisting the MCO in determining the level of care coordination services needed by him or her; and (4) determining the need for a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) assessment, as applicable.

(2) The MCO shall provide the following to every member during the HRA:

(a) information about the services are available through care coordination;

(b) notification of the LOC care coordination

(c) notification of the member's right to request a higher level of care coordination;

(d) requirement for an in-person comprehensive needs assessment for the purpose of providing services associated with care coordination levels 2 or 3; and

(e) information detailing specific next steps for the member.

C. **Assignment to care coordination levels**

(1) Within seven calendar days of completion of the HRA, a member shall be informed of either a level 1 care coordination assignment or the need for a comprehensive needs assessment to determine the need for a level 2 or level 3 care coordination.

(2) Within 10 calendar days of completion of the HRA, the member shall receive:

(a) contact information for the contractor's care coordination unit;

(b) the name of the assigned care coordinator if applicable; and

(c) a timeframe during which he or she can expect to be contacted by the care coordination unit or individual care coordinator which is based on the level of care coordination assigned.

D. Level 1 Care Coordination: a member who is assigned his level will not receive a comprehensive needs assessment and is not assigned an individual care coordinator.

E. Level 2 and Level 3 Care Coordination: for a member meeting one of the indicators below shall have a comprehensive needs assessment conducted by the MCO to determine whether the member should be in level 1 or level 2 care coordination. The member:

(1) is a high-cost user as defined by the MCO;

(2) is in out-of-state medical placement;

(3) is a dependent child in out-of-home placement;

(4) is a transplant patient;

(5) is identified as having a high risk pregnancy;

(6) has a behavioral health diagnosis including substance abuse that adversely affects the his or her life;

(7) is medically fragile or is an ISHCN;

(8) is designated as an ICF/IID or has a HSD-recognized developmental delay (DD);

(9) has high emergency room use as defined by the MCO;

(10) has an acute or terminal disease;

(11) is readmitted to the hospital within 30 calendar days of discharge; or

(12) has other indicators as prior approved by HSD.

F. **Care Coordination Requirements for Level 1:** Each member will receive, at a minimum, the following care coordination:

(1) a HRA annual review to determine if a higher LOC coordination is needed; and

(2) a review of claims and utilization data at least quarterly to determine if he or she is in need of a comprehensive needs assessment and potentially higher LOC coordination.

G. **Comprehensive Needs Assessment for Level 2 and Level 3 Care Coordination:**

(1) The MCO shall schedule an in-person comprehensive needs assessment within 14 calendar days of the member receiving notification of the need for a comprehensive needs assessment for a level 2 or level 3 care coordination assignment.

(2) Within 30 calendar days of the HRA, the MCO shall complete the comprehensive needs assessment.

(3) The comprehensive needs assessment shall be conducted at least annually or as the care coordinator deems necessary (1) as a result of a request from the member, provider or family member ;or (2) as a result of change in the member's health status.

(4) At a minimum, the comprehensive needs assessment shall:

(a) assess the member's physical, behavioral health, and long-term care and social needs; and

(b) identify targeted needs, such as improving health, functional outcomes, or quality of life

outcomes.

H. **Care Coordination Services Requirements for Level 2:** The MCO shall assign a specific care coordinator to each member in level 2. The care coordinator for a member in level 2 shall, at the minimum, arrange for or provide the following care coordination:

(1) the development and implementation of a care plan;
(2) the monitoring of the care plan to determine if the plan is meeting the members identified needs
(3) the assessment of need for assignment to a health home;
(4) targeted health education, including disease management;
(5) the annual comprehensive needs assessment;
(6) the semi-annual in-person visits with the member; and
(7) the quarterly telephone contact with the member.

I. **Care Coordination Requirement for Level 3:** The MCO shall assign a specific care coordinator to each member in level 3. The care coordinator for a member in level 3 shall arrange for or provide the following care coordination services:

(1) the development and implementation of a care plan;
(2) the monitoring care plan to determine if the plan is meeting the member's identified needs;
(3) the assessment of need for assignment to a health home;
(4) targeted health education, including disease management;
(5) the semi-annual comprehensive needs assessment;
(6) the quarterly in-person visits with the member; and
(7) monthly telephone contact with the member.

J. **Increase in the Level of Care Coordination Services:**

(1) The following triggers, a a minimum, shall identify a member's need for a comprehensive needs assessment for a higher level of care coordination:

(a) a referral from his or her primary care provider (PCP), a specialist, another provider, or from another referral source;
(b) his or her self-referral or a referral by his or her authorized representative;
(c) a referral from his or hers MCO staff or at the request from HSD;
(d) the notification of a hospital admission or emergency room visit; and
(e) the claims or encounter data, hospital admission, discharge data, pharmacy data and data collected through the MCO's utilization management (UM) or the quality management (QM) processes.

(2) The MCO shall contact the member within 10 calendar days of receiving the referral, or request, or while conducting a data review or becoming aware of a change in the member's condition, to conduct the comprehensive needs assessment for a higher level of care coordination.

K. **Care Plan Requirements:**

(1) The MCO shall develop and implement care plan for a member in level 2 or 3 care coordination within 14 calendars days of the completion of the comprehensive needs assessment.

(2) The MCO is not required to develop and implement a care plan for a member in level 1 care coordination.

(3) The MCO shall ensure the member and his or her authorized representative participate in the development of the care plan.

(4) The MCO shall ensure the care coordinator consults with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed in the development of the care plan.

J. **On-Going Reporting:** The MCO shall require that the following information about the member's care is shared amongst medical, behavioral health, and long-term care providers:

(1) drug therapy;
(2) laboratory and radiology results;
(3) sentinel events, such as hospitalization, emergencies, or incarceration;
(4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care or from other behavioral health services; and
(5) all LOC transitions.

K. Electronic Visit Verification System

(1) The MCO, together with the other MCOs, shall contract with a vendor to implement an electronic visit verification system to monitor the member's receipt of and utilization of a covered community benefit.

(2) The MCO shall monitor and use information from the electronic verification system to verify

services are provided as specified in the member's care plan, and in accordance with the established schedule, including the amount, frequency, duration, the scope of each service, that services are provided by the authorized provider; and to identify and immediately address service gaps, including late and missed visits. The MCO shall monitor services anytime a member is receiving services, including after the MCO's regular business hours.
[8.308.10.9 NMAC – N, 1-1-14]

HISTORY OF 8.308.10 NMAC:
[RESERVED]

MANAGED CARE PROGRAM
TRANSITION OF CARE

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 11 TRANSITION OF CARE

8.308.11.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.11.1 NMAC - N, 1-1-14]

8.308.11.2 SCOPE: This rule applies to the general public.
[8.308.11.2 NMAC - N, 1-1-14]

8.308.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.11.3 NMAC - N, 1-1-14]

8.308.11.4 DURATION: Permanent.
[8.308.11.4 NMAC - N, 1-1-14]

8.308.11.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.11.5 NMAC - N, 1-1-14]

8.308.11.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.11.6 NMAC - N, 1-1-14]

8.308.11.7 DEFINITIONS: [RESERVED].
[8.308.11.7 NMAC - N, 1-1-14]

8.308.11.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.11.8 NMAC - N, 1-1-14]

8.308.11.9 TRANSITION OF CARE: Transition of care refers to movement of an eligible recipient or a MCO member from one health care practitioner or setting to another as his or her condition and health care needs change. The MCO shall have the resources, the policies and the procedures in place to actively assist the member with his or her transition of care. Care coordination will be provided to a member transitioning from an institutional facility, such as a hospital, a nursing home, a residential treatment facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) back into his or her community. A member changing from MCO to MCO, or from fee-for-service (FFS) to a MCO, or vice versa shall continue to receive medically necessary services in an uninterrupted manner.

A. The following is a list of HSD's general MCO requirements for transition of care.

(1) The MCO shall establish policies and procedures to ensure that each member is contacted in a timely manner and is appropriately assessed by its MCO, using the HSD prescribed timeframes, processes and tools to identify his or her needs.

(2) The MCO shall have policies and procedures covering the transition an eligible recipient into a MCO, which shall include: (a) the member and provider educational about the MCO; (b) self-care and the optimization of treatment; and (c) the review and update of existing courses of the member's treatment.

(3) The MCO shall not transition a member to another provider for continuing services, unless the current provider is not a contracted provider.

(4) The MCO shall facilitate a seamless transition into a new service, a new provider, or both, in a care plan developed by the MCO without disruption in the member's services.

(5) When a member of a MCO is transitioning to another MCO, the receiving MCO shall immediately contact the member's relinquishing MCO and request the transfer of "*transition of care data*" as specified by HSD. If a MCO is contacted by another MCO requesting the transfer of "*transition of care data*" for a transitioning member, then upon verification of such a transition, the relinquishing

MCO shall provide such data in the timeframe and format specified by HSD to the receiving MCO, and both MCOs shall facilitate a seamless transition for the member.

(6) The receiving MCO will ensure that its newly transitioning member is held harmless by his or her provider for the costs of medically necessary covered services, except for applicable cost sharing.

(7) For a MAD medically necessary covered service provided by a contracted provider, the MCO shall provide continuation of such services from that provider, but may require prior authorization for the continuation of such services from that provider beyond 30 calendar days. The receiving MCO may initiate a provider change only as specified in the MCO agreement with HSD.

(8) The receiving MCO shall continue providing services previously authorized by HSD or its designee in the member's approved community benefit care plan, behavioral health treatment plan or service plan without regard to whether such a service is provided by contracted or non-contracted provider. The receiving MCO shall not reduce the service until the member's care coordinator has conducted a comprehensive needs assessment and developed a care plan.

B. **Transplant services, durable medical equipment and prescription drugs:**

(1) When an eligible recipient received HSD approval, either through FFS or any other HSD contractor, the receiving MCO shall reimburse the HSD approved providers if a donor organ becomes available during the first 30 calendar days of the member's MCO enrollment.

(2) When a member was approved by its MCO for transplant services, HSD shall reimburse the MCO approved providers if a donor organ becomes available during the first 30 calendar days of the eligible recipient's FFS enrollment. The MCO provider who delivers these services will be eligible for FFS enrollment if the provider is willing.

(3) When a member received approval from his or her MCO for durable medical equipment (DME) costing $2,000 or more, and prior to the delivery of the DME item, was disenrolled from the MCO, the relinquishing MCO shall pay for the item.

(4) When an eligible recipient received FFS approval for a DME costing $2,000 or more, and prior to the delivery of the DME item, he or she was enrolled in a MCO HSD shall pay for the item. The DME provider will be eligible for FFS provider enrollment if the provider is willing.

(5) When a FFS eligible recipient is later enrolled in a MCO, the receiving MCO shall pay for prescribed drug refills for the first 30 calendar days or until the MCO has made other arrangements.

(6) When a MCO member is later determined to be exempt from MCO enrollment, HSD will pay for prescription drug refills for the first 30 calendar days of his or her FFS enrollment. The pharmacy provider will be eligible for FFS enrollment if the provider is willing;

(7) When a FFS eligible recipient is later enrolled in a MCO, the receiving MCO will honor all prior authorizations granted by HSD or its contractors for the first 30 calendar days or until it has made other arrangements for the transition of services. A provider who delivered services approved by HSD or through its contractors shall be reimbursed by the receiving MCO.

(8) When a MCO member is later determined to be exempt from MCO enrollment, HSD will honor the relinquishing MCO's prior authorizations for the first 30 calendar days or until other arrangements for the transition of services have been made. The provider will be eligible for FFS enrollment if the provider is willing.

C. **Transition of Care Requirements for Pregnant Women:**

(1) When a member is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prenatal care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

(2) When a newly enrolled member is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment, the receiving MCO shall be responsible for the costs of continuation of such medically necessary prenatal care services, including prenatal care and delivery, without any form of prior approval from the receiving MCO and without regard to whether such services are being provided by a contracted or non-contracted provider for up to 60 calendar days from her MCO enrollment or until she may be reasonably transferred to a MCO contracted provider without disruption in care, whichever is less.

(3) When a member is receiving services from a contracted provider, her MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the two month postpartum period.

(4) When a member is receiving services from a non-contracted provider, her MCO will be responsible for the costs of continuation of medically necessary covered prenatal services, delivery, through the two month postpartum period, without any form of prior approval, until such time when her MCO determines it can

reasonably transfer her to a contracted provider without impeding service delivery that might be harmful to her health.

D. **Transition from Institutional Facility to Community:**

(1) The MCO shall develop and implement methods for identifying members who may have the ability, the desire or both to transition from institutional care to his or her community. Such methods include, at a minimum:

(a) the utilization of a comprehensive needs assessment;
(b) the utilization of the preadmission screening and annual resident review (PASRR);
(c) minimum data set (MDS);
(d) the identification of wrap-around services;
(e) a provider referral;
(f) an ombudsman referral;
(g) a family member referral;
(h) the change in medical status; and
(i) the member's self-referral.

(2) When a member's transition assessment indicates that he or she is a candidate for transition to the community, his or her MCO care coordinator shall facilitate the development of and completion of a transition plan, which shall remain in place for a minimum of 90 calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The transition plan shall address the member's transition needs including but not limited to:

(a) his or her physical and behavioral health needs;
(b) the selection of providers in his or her community;
(c) continuation of MAD eligibility;
(d) his or her housing needs;
(e) his or her financial needs;
(f) his or her interpersonal skills; and
(g) his or her safety.

(3) The MCO shall conduct an additional assessment within 75 calendar days of the member's transition to his or her community to determine if the transition was successful and identify any remaining needs of the member.

E. **Transition from the New Mexico Health Insurance Exchange:**

(1) The receiving MCO must minimize the disruption of the newly enrolled member's care and ensure he or she has uninterrupted access to medically necessary services when transitioning between a MCO and his or her New Mexico health insurance exchange qualified health plan coverage.

(2) At a minimum, the receiving MCO shall establish transition guidelines for the following populations:

(a) pregnant members, including the two month postpartum period;
(b) members with complex medical conditions;
(c) members receiving ongoing services or who are hospitalized at the time of transition; and
(d) members who received prior authorization for services from his or her qualified health plan.

(3) The receiving MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these populations, and to maintain written policies, procedures and the documentation to address coverage transitions.

[8.308.11.9 NMAC - N, 1-1-14]

HISTORY OF 8.308.11 NMAC: [RESERVED]

**MEDICAID MANAGED CARE
REIMBURSEMENT**

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MEDICAID MANAGED CARE
PART 20 REIMBURSEMENT

8.308.20.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.20.1 NMAC - N, 1-1-14]

8.308.20.2 SCOPE: This rule applies to the general public.
[8.308.20.2 NMAC - N, 1-1-14]

8.308.20.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.20.3 NMAC - N, 1-1-14]

8.308.20.4 DURATION: Permanent.
[8.308.20.4 NMAC - N, 1-1-14]

8.308.20.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.20.5 NMAC - N, 1-1-14]

8.308.20.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.20.6 NMAC - N, 1-1-14]

8.308.20.7 DEFINITIONS: [RESERVED]
[8.308.20.7 NMAC - N, 1-1-14]

8.308.20.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.20.8 NMAC - N, 1-1-14]

8.308.20.9 REIMBURSEMENT FOR MANAGED CARE:

A. **Payment for services**: HSD shall make actuarially sound payments, in accordance with 42 C.F.R. 438.6(c), for the provision of the managed care medicaid benefit package, under capitated risk contracts to the designated managed care organizations (MCOs). Rates whether set by HSD or negotiated between HSD and the MCO are confidential.

(1) At the sole discretion of HSD, rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. Rates may be adjusted based on factors, including but not limited to, changes in the scope of work; CMS requiring a modification of the 1115(a) waiver; new or amended federal or state statutes, regulations or rules; inflation; significant changes in the demographic characteristics of the member population; or the disproportionate enrollment selection of the MCO by members in certain rate cohorts.

(2) The MCO shall be responsible for the provision of services for members during the month of capitation. A medicaid eligible recipient shall not be liable for debts or costs incurred by an MCO under the MCO's managed care contract for providing health care to him or her. This includes but is not limited to:

(a) the MCO's debts in the event of its insolvency;

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

(c) instances when the MCO does not pay the health care provider who furnishes the services under contractual, referral, or other arrangement;

(d) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly; and

(e) if a MCO member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO shall accept a retroactive capitation payment for that month of eligibility and

assume financial responsibility for all medically-necessary covered benefit services supplied to the member. Retroactive capitation payments may not be issued for a member for the same coverage month in which fee-for-service claims have already been paid by HSD except in special situations determined by HSD.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the MCO for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO shall accept the capitation rate paid each month by HSD as payment in full for all services including all administrative costs associated therewith, including gross receipts tax payable to the provider. The MCO is at risk of incurring losses if the cost of providing the managed care medicaid benefit package exceeds its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

C. **Capitation recoupments:** HSD shall have the discretion to recoup capitations or payments as provided for in its contract with the MCO.

(1) Instances when HSD shall recoup payments for members include, but are not limited to:

(a) member incorrectly enrolled with more than one MCO;

(b) member who dies prior to the enrollment month for which payment was made; or

(c) member who HSD later determines was not eligible for medicaid during the enrollment month, including retroactive months for which payment was made.

(2) HSD acknowledges and agrees that in the event of any recoupment pursuant to this rule, the MCO shall have the right to recoup from a provider or another person to whom the MCO has made payment during this period of time; however, may not recoup payments for any value added services provided. Recouped payments to a provider is subject to the time periods governed by the MCO provider agreement.

(3) Any duplicate payment identified by either the MCO or HSD shall be recouped upon identification.

(4) The MCO has the right to dispute any recoupment action in accordance with contractual provisions.

D. **Patient Liability:** HSD monthly capitation payments will be net of patient liability. The capitation payments are developed on "gross" cost and will be reduced by the amount of average patient member responsibility each month. The MCO shall delegate the collection of patient member liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient member liability amount. The MCO shall submit patient member liability information associated with claim payments in their encounter data submissions.

E. **Payment time frames:** A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: (a) 90 percent within 30 calendar days of the date of receipt and (b) 99 percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The date of receipt is the date the MCO first receives the claim either manually or electronically. The MCO is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this requirement may be made if the MCO and its providers by mutual agreement establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO. The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD HSD

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

(3) If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

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

(1) Reimbursement to a federally qualified health center (FQHC) and a rural health clinic (RHC): a contracted and non-contracted FQHC or RHC shall be reimbursed at a minimum of the prospective payment system (PPS) as determined by HSD or its designee or an alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act, as established by HSD.
Act as approved by HSD.

(2) Reimbursement to Indian health service (IHS), tribal health providers, and urban Indian providers authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

(a) The MCO shall reimburse IHS and tribal compact contracted and non-contracted provider as identified by HSD, at a minimum of 100 percent of the rate established for an IHS facility or federally-leased facility by the office of management and budget (OMB). For services designated by HSD to be paid at fee schedule rates rather than OMB rates, the MCO shall reimburse the IHS or tribal contract provider at not less than the MAD fee schedule rate.

(b) The MCO shall have up to two years from a claim's first date of service to submit a claim; claims not submitted within two years of the first date of service are not eligible for reimbursement.

(e) With the exception of residential treatment center services, services provided by IHS or a tribal 638 facility is not subject to prior authorization.

(3) Reimbursement for family planning services: the MCOs shall reimburse an out-of-network family planning provider for services provided to a MCO member at a rate that is at least equal to the MAD fee-schedule rate for the provider type.

(4) Reimbursement for a woman in her second or third trimester of pregnancy: If a woman is in the second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prental care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

(5) Reimbursement for a MCO member who disenrolls transitions while hospitalized: If an eligible recipient is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health (DOH). The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the receiving MCO receiving capitation payments. The relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from the MCO.
[8.308.20.9 NMAC - N, 1-1-14]

HISTORY OF 8.308.20 NMAC:

MANAGED CARE PROGRAM
QUALITY MANAGEMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 21 QUALITY MANAGEMENT

8.308.21.1 ISSUING AGENCY: Human Services Department (HSD).
[8.308.21.1 NMAC - N, 1-1-14]

8.308.21.2 SCOPE: This rule applies to the general public.
[8.308.21.2 NMAC - N, 1-1-14]

8.308.21.3 STATUTORY AUTHORITY: The New Mexico Medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.21.3 NMAC - N, 1-1-14]

8.308.21.4 DURATION: Permanent.
[8.308.21.4 NMAC - N, 1-1-14]

8.308.21.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.21.5 NMAC - N, 1-1-14]

8.308.21.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs.
[8.308.21.6 NMAC - N, 1-1-14]

8.308.21.7 DEFINITIONS: [RESERVED].
[8.308.21.7 NMAC - N, 1-1-14]

8.308.21.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.
[8.308.21.8 NMAC - N, 1-1-14]

8.308.21.9 QUALITY MANAGEMENT: A HSD managed care organization (MCO) quality management program includes a philosophy, a method of management, and a structured system designed to improve the quality of services; includes both quality assurance and quality improvement activities; and is incorporated into the health care delivery and administrative systems.

A. Quality management (QM) program structure: The MCO shall have QM structure and processes. See the MAD policy manual XXX.

B. QM program description: The MCO shall develop a written QM and a quality improvement (QI) program description that includes the requirements described in the MAD policy manual.

C. QM and QI program principles: The MCO QM and QI programs are based on principles of continuous quality improvement (CQI) and total quality management (TQM). Such an approach will:

(1) recognize clinical and non-clinical opportunities are unlimited;
(2) be data driven;
(3) use real-time input from members and MCO contracted providers to develop CQI activities; and
(4) require on-going measurement of effectiveness and improvement.

D. QM program evaluation: The MCO will have a written QM and QI program evaluation as described in the MAD policy manual.
[8.308.21.9 NMAC - N, 1-1-14]

8.308.21.10 DISEASE MANAGEMENT: The MCO will have a disease management program as described in the policy manual.
[8.308.21.10 NMAC - N, 1-1-14]

8.308.21.11 CLINICAL PRACTICE GUIDELINES: As described in the policy manual, the MCO will

have a process to adopt, review, update and disseminate evidence-based clinical practice guidelines, practice parameters, consensus statements, and specific criteria for the provision of acute and chronic physical and behavioral health care services.
[8.308.21.11 NMAC - N, 1-1-14]

8.308.21.12 PERFORMANCE IMPROVEMENT: The MCO will implement performance assessment and improvement activities as described in the policy manual.
[8.308.21.12 NMAC - N, 1-1-14]

8.308.21.13 INCIDENT MANAGEMENT: Critical incident reporting and management is considered part of ongoing quality management. Critical incident reporting and analysis of critical incident data helps to identify causes of adverse events in critical care and areas of focus for implementation of preventative strategies.

A. MCO incident management principles: The implementation of incident management practices and effective incident reporting processes are based on the following MAD MCO principles:

(a) a member is expected to receive home and community based services free of abuse, neglect, and exploitation;

(b) training addresses the response to and the report of to include the documentation of a critical incident;

(c) a member, his or her authorized representative will receive information on his or her MCO incident reporting process; and

(d) good faith incident reporting of or the allegation of abuse, neglect or exploitation is free from any form of retaliation.

B. Reportable incidents:

(1) The MCO shall ensure that any person having reasonable cause to believe an incapacitated adult member is being abused, neglected, or exploited must immediately report that information.

(2) The MCO shall develop and provide training covering the MCO's procedures for reporting a critical incident to all subcontracted individual providers, provider agencies, and its members who are receiving self-directed services, to include his or her employees.

(3) The MCO shall comply with all statewide reporting requirements for any incident involving a member receiving a MAD covered home and community based service.

(4) A community agency providing home and community based services is required to report critical incident involving a MCO member, including:

(a) the abuse of him or her;
(b) the neglect of him or her;
(c) the exploitation of him or her;
(d) any incident involving his or her utilization of emergency services;
(e) the hospitalization of him or her;
(f) his or her involvement with law enforcement;
(g) his or her exposure to or the potential of exposure to environmental hazards that compromise his or her health and safety; and
(h) the death of the member.

(5) The MCO shall provide , coordinate, or both, intervention and shall follow up upon the receipt of an incident report that demonstrates the health and safety of its member is in jeopardy.
[8.308.21.13 NMAC - N, 1-1-14]

8.308.21.14 EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO): An EQRO will conduct external, independent reviews of the MCO.

A. The MCO shall fully cooperate with the following mandatory EQRO activities, such as:

(a) the validation of required performance improvement projects (PIP);
(b) the validation of plan performance measures reported by the MCO; and
(c) a review to determine the plan's compliance with state standards for access to care, structure and operations, and QM and QI requirements.

B. The MCO shall fully cooperate with the following EQRO optional activities:

(a) the validation of encounter data reported by the plan;
(b) the administration and the validation of member and provider surveys on the quality of care;

(c) the calculation of additional performance measures;
(d) conducting additional PIPs validations; and
(e) conducting studies on quality focused on a particular aspect of clinical or nonclinical services at a specific point in time.
[8.308.21.14 NMAC - N, 1-1-14]

8.308.21.15 QUALITY MANAGEMENT COMMITTEE: The MCO must have a planned, systematic and ongoing process for monitoring, evaluating and improving the quality and appropriateness of services provided to its members. A QM committee will provide oversight to quality monitoring and improvement activities, including safety review and the assignment of accountability.

A. Quality review:

(1) The MCO shall establish a review committee to act as the leadership body for QI activities. The review committee acts to identify and facilitate the accomplishment of a planned, systematic, valid, and valuable QM plan for members and its providers.

(2) The review committee will monitor key services delivered to members and associated supportive processes to include:
(a) the utilization of services;
(b) its member satisfaction;
(c) its clinical services, including disease management; and
(d) its administrative services.

(3) The review committee is authorized to take action upon issues related to member care and make recommendations related to contracts, compensation, and provider participation.

B. Critical incident review:

(1) The MCO shall establish a review committee to review events that result in a serious and undesired consequence; events that are not a result of an underlying health condition or from a risk inherent in providing health services, including:
(a) death;
(b) disability; and
(c) injury or harm to the member.

(2) The committee is authorized to make recommendations for the prevention from future harm of its members, as well as its system process improvement.

C. Oversight: The MCO will provide HSD with reports and records to ensure compliance with quality review and critical incident review requirements.
[8.308.21.15 NMAC - N, 1-1-14]

8.308.21.16 MEDICAL RECORDS: The member's medical records shall be legible, timely, current, detailed and organized to permit effective and confidential patient care and quality reviews.

A. The MCO shall have medical record confidentiality policies and procedures and medical record documentation standards for its providers and subcontractors.

B. The MCO shall have: (1) a process to review medical records to ensure compliance with MCO policy, procedures and standards; and (2) shall cooperate with the EQRO in its review of medical records to ensure compliance with its medical record policy and standards.

C. The MCO shall:

(1) provide HSD or its designee access to a member's medical and behavioral health records;

(2) include provisions in contracts with providers for MCO and HSD or its designee, access to member medical records for the purposes of compliance or quality review;

(3) ensure that the assigned primary care provider (PCP), the patient centered medical home or the patient centered health home maintain a primary medical and as appropriate, behavioral health record for each member. This record must contain sufficient information from each provider involved in the member's care to ensure continuity of care;

(4) ensure all providers involved in the member's care have access to the primary medical record; and

(5) have policies and processes that ensure the confidential transfer of medical and behavioral health information between its providers, its agencies or other health plans.
[8.308.21.16 NMAC - N, 1-1-14]

8.308.21.17 UTILIZATION MANAGMENT: A utilization management (UM) program is an organization-

wide, interdisciplinary approach of evaluating the medical necessity, appropriateness, and efficiency of health care services. The MCO shall have an UM program as described in the policy manual.
[8.308.21.17 NMAC - N, 1-1-14]

8.308.21.18 ADVISORY BOARDS: Advisory boards are federally mandated bodies that provide ongoing venues for discussions of policy, operations, service delivery and administrative issues for its members. The MCO will convene and facilitate an advisory board of its members and a Native American advisory board in accordance with the requirements described in the policy manual.
[8.308.21.18 NMAC - N, 1-1-14]

8.308.21.19 SATISFACTION SURVEYS: For the MCO to maintain a comprehensive system of health care that supports quality, as well as cost-effectiveness depends largely on the satisfaction and cooperation of its members and its providers. The MCO will regularly survey these groups following the requirements described in the policy manual.
[8.308.21.19 NMAC - N, 1-1-14]

HISTORY OF 8.308.21 NMAC: [RESERVED]