MEDICAID MANAGED CARE
REIMBURSEMENT FOR MANAGED CARE
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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 11 REIMBURSEMENT FOR MANAGED CARE

8.305.11.1 ISSUING AGENCY: Human Services Department
[8.305.11.1 NMAC - N, 7-1-01]

8.305.11.2 SCOPE: This rule applies to the general public.
[8.305.11.2 NMAC - N, 7-1-01]

8.305.11.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 27-2-12 et. seq. (Repl. Pamp. 1991).
[8.305.11.3 NMAC - N, 7-1-01]

8.305.11.4 DURATION: Permanent
[8.305.11.4 NMAC - N, 7-1-01]

8.305.11.5 EFFECTIVE DATE: July 1, 2001, unless a later date is cited at the end of a section.
[8.305.11.5 NMAC - N, 7-1-01]

8.305.11.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.11.6 NMAC - N, 7-1-01]

8.305.11.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.11.7 NMAC - N, 7-1-01]

8.305.11.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the life of their communities.
[8.305.11.8 NMAC - N, 7-1-01; A, 7-1-09]

8.305.11.9 REIMBURSEMENT FOR MANAGED CARE:

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

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

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

(3) when the MCO/SE does not pay the health care provider that furnishes the services under contractual, referral, or other arrangement;

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

(5) if an MCO/SE member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO/SE shall accept a retro capitation payment for that month of eligibility and assume financial responsibility for all medically necessary covered benefit services supplied to the member.

B. **Capitation disbursement requirements:** HSD shall pay a capitated amount to the MCO/SE for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO/SE shall accept the capitation rate paid each month by HSD as payment in full for all services to be provided pursuant to the agreement, including all administrative costs associated therewith. HSD/MAD will calculate or verify the MCO/SE's income at the end of the state fiscal year to determine if the extent was expended on the services required under the contract utilizing reported information and the department of insurance reports. Administrative costs, to be no higher than the allowable percent, including all MCO/SE-delegated entities (if applicable), and other financial information will be monitored. The MCO/SE does not have the option of deleting benefits from the medicaid defined benefit package. Should the MCO/SE not meet the required administrative or direct services costs within the terms of the contract, sanctions or financial penalties may be imposed.

C. **Payment time frames:** Clean claims as defined in Subsection L of 8.305.1.7 NMAC, *Clean Claim*, shall be paid by the MCO/SE to contracted and noncontracted providers according to the following timeframe: 90 percent within 30 days of the date of receipt and 99 percent within 90 days of the date of receipt, as required by federal guidelines in the Code of Federal Regulations, Section 42 CFR 447.45. The date of receipt is the date the MCO/SE first receives the claim either manually or electronically. The MCO/SE is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this rule may be made if the MCO/SE and its providers, by mutual agreement, establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO/SE. The MCO/SE shall be financially responsible for paying all claims for all covered emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) An MCO/SE shall pay contracted and noncontracted providers interest on the MCO's/SE's liability at the rate of 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 days of the date of receipt of an electronic claim and 45 days of receipt of a manual claim. Interest shall accrue from the 31st day for electronic claims and from the 46th day for manual claims. The MCO/SE shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

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

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

D. **Rate setting:** Capitation rates paid by HSD to the MCO/SE for the provision of the managed care medicaid benefit package shall be calculated through actuarial analysis, be actuarially sound and meet the standards set by 42 CFR 438.6(c).

E. **Payment on risk basis:** The MCO/SE is at risk of incurring losses if its costs of providing the managed care medicaid benefit package exceed its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO/SE to reflect the actual cost of services furnished by the MCO/SE.

F. **Change in capitation rates:** HSD shall review the capitation rates 12 months from the effective date of the contract and annually thereafter. HSD may adjust the capitation rates based on factors such as the following: changes in the scope of work; CMS requiring a modification of the state's waiver; if new or amended federal or state laws or regulations are implemented; inflation; or if significant changes in the demographic characteristics of the member population occur.

G. **Solvency requirements and risk protections:** An MCO/SE that contracts with HSD to provide medicaid physical or behavioral health services shall comply with, and be subject to, all applicable state and federal laws and regulations, including solvency and risk standards. In addition to requirements imposed by state and federal law, the MCO/SE shall be required to meet specific medicaid financial requirements and to provide to HSD the information and records necessary to determine the MCO's/SE's financial condition. Requests for information

and records shall be delivered to HSD, at no cost to HSD, in a reasonable time after the date of request or as specified in the contract.

(1) **Reinsurance:** An MCO/SE participating in medicaid managed care shall purchase reinsurance at a minimum of $1,000,000.00 in reinsurance protection against financial loss due to outlier (catastrophic) cases. The MCO shall document for HSD that reinsurance is in effect through the term of the contract and that the amount of reinsurance is sufficient to cover probable outlier cases or overall member utilization at an amount greater than expected. Pursuant to 42 CFR 438.6(e)(5), contract provisions for reinsurance, stop-loss limits, or other risk sharing methodologies shall be computed on an actuarially sound basis.

(2) **Third party liability (TPL):** The MCO/SE shall be responsible for identifying a member's third party coverage and coordinating of benefits with third parties as required by federal law. The MCO/SE shall inform HSD when a member has other health care insurance coverage. The MCO shall have the sole right of subrogration, for 12 months, from when the MCO incurred the cost on behalf of the members, to initiate recovery or to attempt to recover any third-party resources available to medicaid members and shall make records pertaining to third party collections (TPL) for members available to HSD/MAD for audit and review. If the MCO has not initiated recovery or attempted to recover any third-party resources available to medicaid members within 12 months, HSD will pursue the member's third party resources. The MCO/SE shall provide to HSD for audit and review all records pertaining to TPL collections for members.

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

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

(5) **Solvency cash reserve requirement:** The MCO/SE shall have sufficient reserve funds available to ensure that the provision of services to medicaid members is not at risk in the event of MCO/SE insolvency.

(6) **Per enrollee cash reserve:** The MCO/SE shall maintain three percent of the monthly capitation payments per member with an independent trustee during each month of the agreement. HSD shall adjust this cash reserve requirement annually, or as needed, based on the number of the MCO's/SE's members, or the failure of the MCO/SE to maintain the required cash reserve, and shall notify the MCO/SE of the cash reserve requirement. Each MCO/SE shall maintain its own cash reserve account. This account may be accessed solely for payment for services to the MCO's/SE's members in the event that the MCO/SE becomes insolvent. Money in the reserve account remains the property of the MCO/SE, and any interest earned (even if retained in the account) shall be the property of the MCO/SE. Failure to maintain the reserve as directed above will result in financial penalties equal to 25 percent of the amount of shortfall in the account each month. If the cash reserve account exceeds 105 percent of an amount equal to three percent of the annualized capitation as determined above, for more than two months, HSD will direct the MCO/SE to reduce the reserve to the 100 percent level and the MCO/SE shall comply with such direction within 30 days.

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

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

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

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

(3) **Reimbursement for family planning services:** The MCOs shall reimburse out-of-network family planning providers for services provided to MCO members at a rate at least equal to the medicaid fee-for-service rate for the provider type.

(4) **Reimbursement for women in the third trimester of pregnancy:** If a woman in the third trimester of pregnancy at the time of her enrollment in managed care has an established relationship with an obstetrical provider and desires to continue that relationship and the provider is not contracted with the MCO, the MCO shall reimburse the out-of-network provider for care directly related to the pregnancy, including delivery and a six-week post-partum visit.

(5) **Reimbursement for members who disenroll while hospitalized:** Regarding Salud! MCO and medicaid fee-for-service (FFS) members: if an MCO or FFS member is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health. The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the organization or entity receiving capitation payments or FFS in the case of disenrollment from Salud! Regarding Salud! MCO and CoLTS MCO members: for members transitioning to or from CoLTS, the originating MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from Salud! to CoLTS or disenrollment from CoLTS to Salud! For either transition, services provided at a free-standing psychiatric hospital or within a psychiatric unit of an acute care hospital are the responsibility of the SE.

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

J. **Recoupment payments:** HSD shall recoup payments for MCO members who are incorrectly enrolled with more than one MCO, including members categorized as newborns or X5; payments made for MCO/SE members who die prior to the enrollment month for which payment was made; or payments to the MCO/SE for members whom HSD later determines were not eligible for medicaid during the enrollment month for which payment was made. Any duplicate payment identified by either the MCO/SE or HSD shall be recouped upon identification. In the event of an error, which causes payment(s) to the MCO/SE to be issued by HSD, HSD shall recoup the full amount of the payment. Interest shall accrue at the statutory rate on any amounts not paid and determined to be due after the 30th day following the notice. Any process that automates the recoupment procedures shall be discussed in advance by HSD and the MCO/SE and documented in writing, prior to implementation of the new automated recoupment process. The MCO/SE has the right to dispute any recoupment action in accordance with contractual provisions.

K. HSD shall pay interest at nine percent per annum on any capitation payment due to the MCO/SE that is more than 30 days late. No interest or penalty shall accrue for any other late payments or reimbursements.

L. HSD may initiate alternate payment methodology for specified program services or responsibilities.

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

HISTORY OF 8.305.11 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.10 Managed Care Policies, Reimbursement for Managed Care, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.10 Managed Care Policies, Reimbursement for Managed Care - Repealed, 7-1-01.