MEDICAID MANAGED CARE
PROVIDER NETWORKS
Tribal Consultation Version 10.15.2013

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

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

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

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

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

8.305.6.5 EFFECTIVE DATE: January 1, 2004, unless a later date is cited at the end of a section.
[8.305.6.5 NMAC - N, 7-1-01]

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

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

8.305.6.8 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.
[8.305.6.8 NMAC - N, 7-1-01; A, 7-1-09]

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

A. **Service coverage:** The MCO/SE shall provide or arrange for the provision of services described in 8.305.7 NMAC, *Benefit Package*, in a timely manner. The MCO/SE is solely responsible for the provision of covered services and must ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards.

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

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

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

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

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

(1) the nature of the change;
(2) how the change affects the delivery of or access to covered services; and
(3) the MCO's/SE's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO/SE shall maintain policies and procedures on provider recruitment and termination of provider participation with the MCO/SE. The recruitment policies and procedures shall describe how an MCO/SE responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO/SE:

(1) must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
(2) must not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;
(3) must not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;
(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;
(5) shall be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty;
(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;
(7) may not employ or contract with providers or entities excluded from participation in federal health care programs because of misconduct; and
(8) shall not be required to contract with providers who are ineligible to receive reimbursement under medicaid fee-for-service.

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

8.305.6.10 PROVIDER QUALIFICATIONS & CREDENTIALING: The MCO/SE shall verify that each contracted or subcontracted provider (practitioner or facility) participating in, or employed by, the MCO/SE meets applicable federal and state requirements for licensing, certification, accreditation and recredentialing for the type of care or services within the scope of practice as defined by federal medicaid statutes and state law.
[8.305.6.10 NMAC - Rp 8 NMAC 4.MAD.606.5.2, 7-1-01; A, 7-1-05]

8.305.6.11 UTILIZATION OF OUT-OF-STATE PROVIDERS: To the extent possible, the MCO/SE 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/SE may include out-of-state providers in the network.
[8.305.6.11 NMAC - Rp 8 NMAC 4.MAD.606.5.3, 7-1-01; A, 7-1-05]

8.305.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) must be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall

distribute information to the providers explaining the medicaid-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall develop policies and procedures to ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

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

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

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

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

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

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

(8) governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with the assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request. A PCP change may also be initiated on behalf of a member by the member's parents or legal guardians of a minor or incapacitated adult.

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

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

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

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

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

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

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

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

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

8.305.6.13 SPECIALTY PROVIDERS:

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

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

C. A woman in her third trimester of pregnancy at the time of enrollment, who has an established obstetrical provider, may maintain that relationship. (Refer to Paragraph (4) of Subsection H of 8.305.11.9 NMAC, *Reimbursement for Women in the Third Trimester of Pregnancy*.)

D. The MCO/SE or a specialist may initiate a change of specialists when the member's/guardian's behavior toward the specialist is such that it has made all reasonable efforts to accommodate the member /guardian and address the member's problems, but those efforts have been unsuccessful.

[8.305.6.13 NMAC - Rp 8 NMAC 4.MAD.606.5.5, 7-1-01; A, 7-1-04; A, 7-1-05]

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

A. **Provider to member ratios:**

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

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

B. **Compliance with specified access standards:** The MCO/SE shall comply with all access standards delineated under the terms of the medicaid managed care contract with respect to geographic location, scheduling time and waiting times.

C. **Requirements for MCO/SE policies and procedures:** The MCO/SE shall maintain written policies and procedures describing how members and providers receive instructions on access to services including prior authorization and referral requirements for various types of medical or surgical treatments, emergency room services, and behavioral health services. The policies and procedures shall be made available in an accessible format, upon request, to HSD, network providers and members.

[8.305.6.14 NMAC - Rp 8 NMAC 4.MAD.606.5.6, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.15 PUBLICLY SUPPORTED PROVIDERS: The MCO/SE shall demonstrate how it incorporates and utilizes certain publicly supported providers who serve many of the special needs of medicaid members and are considered important in maintaining continuity of care.

A. **Federally qualified health centers (FQHCs):** The MCO/SE shall contract with FQHCs to the extent that access is required by federal law and in accordance with the Section 1915(b) waiver granted by CMS to the state. The MCO/SE shall contract with at least one FQHC specializing in health care for the homeless in Bernalillo county and one urban Indian FQHC. An MCO/SE with a contracted FQHC, that has no capacity to accept new members does not satisfy this requirement. If an MCO/SE cannot meet the standard for FQHC access during the medicaid managed care contract period, the MCO/SE shall allow its members to seek care from nonparticipating FQHCs. If the MCO/SE and the FQHC cannot reach agreement as to reimbursement for services, the MCO/SE shall agree to pay medicaid fee-for-service rates for the service in question.

B. **Local department of health offices:** The MCO shall contract with public health providers for services described below in Paragraph (2) of Subsection B of 8.305.6.15 NMAC and those defined by state law as public health services.

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

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

(a) family planning services;

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

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

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

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

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

(c) screening, diagnosis and treatment of tuberculosis;

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

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

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

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

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

(i) vaccines for children program.

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

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

E. **Indian health services (IHS) and tribal health centers:** The MCO/SE shall allow members who are Native American to seek care from IHS, tribal or urban Indian program providers defined in the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), whether or not the provider participates as part of the MCO's or SE's provider network. The MCO/SE may not prevent members who are IHS beneficiaries from seeking care from IHS, tribal or urban Indian providers. The MCO/SE shall enter into contracts with "essential" providers that include, but are limited to, IHS, 638 tribal programs and providers serving particular linguistic or cultural groups.
[8.305.6.15 NMAC - Rp 8 NMAC 4.MAD.606.5.7, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.16 FAMILY PLANNING PROVIDERS: Federal law does not allow restricting access to family planning services for individuals enrolled in medicaid. The MCO shall maintain policies and procedures defining how members are educated about their right to family planning services, freedom of provider choice and method of accessing such services. The MCO shall ensure its policies and procedures for accessing family planning services meet specified requirements for member communication. The MCO shall implement procedures to reimburse out-of-network family planning providers who serve its members.
[8.305.6.16 NMAC - Rp 8 NMAC 4.MAD.606.5.8, 7-1-01]

8.305.6.17 PROVIDER EDUCATION AND COMMUNICATION:

A. The MCO/SE shall establish and maintain policies and procedures governing the development and distribution of education and informational materials regarding managed care, including behavioral health, to its network providers. Policies and procedures shall:

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

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

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

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

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

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

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

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

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

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

(2) actively solicit input from its network providers in an effort to improve and resolve problem areas related to the medicaid program; the information provided will be incorporated into the MCO's or SE's QI program; and

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

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

[8.305.6.17 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05]

8.305.6.18 MCO/SE PROVIDER TRANSITION OF CARE: The MCO/SE shall notify HSD of unexpected changes to the composition of its provider network that would have a significantly negative effect on member access to services or on the MCO's/SE's ability to deliver services included in the benefit package in a timely manner. In the event that provider network changes are unexpected or when it is determined that a provider is unable to meet their contractual obligation, the MCO/SE shall be required to submit a transition plan(s) to HSD for all affected members.

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

HISTORY OF 8.305.6 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.606.5, Managed Care Policies, Provider Networks, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.5, Managed Care Policies, Provider Networks - Repealed, 7-1-01.