COORDINATED LONG TERM SERVICES
GENERAL PROVISIONS
Tribal Consultation Version 10.15.2013

TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 1 GENERAL PROVISIONS

8.307.1.1 ISSUING AGENCY: Human Services Department (HSD)
[8.307.1.1 NMAC - N, 8-1-08; A, 10-15-12]

8.307.1.2 SCOPE: This rule applies to the general public.
[8.307.1.2 NMAC - N, 8-1-08]

8.307.1.3 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 the Social Security Act as amended or by state statute. See NMSA 1978, Chapter 27, Public Assistance.
[8.307.1.3 NMAC - N, 8-1-08; A, 10-15-12]

8.307.1.4 DURATION: Permanent
[8.307.1.4 NMAC - N, 8-1-08]

8.307.1.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.1.5 NMAC - N, 8-1-08]

8.307.1.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[8.307.1.6 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

8.307.1.7 DEFINITIONS: The state of New Mexico is committed to improving the health status of New Mexico residents whose health care services are funded by the Title XIX (medicaid) program. As a means of improving health status, a coordination of long-term services program has been implemented. This section contains the glossary for the New Mexico medical assistance division (MAD) coordination of long-term services policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

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

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

(3) **Activities of daily living:** Activities necessary for daily living, including eating, dressing, oral hygiene, bathing, mobility, toileting, grooming, taking medications, transferring from a bed or chair, and walking, consistent with NMSA 1978 Section 28-17-3

(4) **Advance directive:** Written instructions relating to the provision of health services when an adult is incapacitated and may include an advance directive, mental health advance directive, living will, durable health care power of attorney, durable mental health care power of attorney, or advance health directive.

(5) **Adverse determination:** A determination by a managed care organization (MCO) or by its utilization review agent, that the health care services furnished or proposed to be furnished to an eligible recipient are not medically necessary or are not appropriate.

(6) **ALTSD:** The New Mexico aging and long-term services department.

(7) **Appeal, eligible recipient:** A request from an eligible recipient or provider, on an eligible recipient's behalf with an eligible recipient's written permission, for review by the MCO. See 8.307.1 NMAC *General Provisions* for the definition of "action".

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

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

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

(11) **Assisted living services:** Residential services that include personal support services, companion services, and assistance with medication administration, as set forth in department of health (DOH) rules 7.8.2 NMAC, *Residential Health Facilities* or its successor.

(12) **At risk:** The period of time that an eligible recipient is enrolled with a MCO or a SE during which the MCO is responsible for providing covered services under capitation.

B. Definitions beginning with letter "B":

(1) **Begin date:** The first day of the first full month following selection or assignment to a MCO. For an eligible recipient resident of a nursing facility (NF) prior to the level of care (LOC) determination, but not enrolled in a MAD MCO or a medicare advantage plan, the begin date will be the first month in which both the NF LOC determination and MAD eligibility exists.

(2) **Behavioral health:** A term used that includes mental health or substance abuse.

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

(4) **Behavioral health purchasing collaborative:** Refers to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271, effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies, including eight agencies that provide and fund direct services, including the human services department.

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

C. Definitions beginning with letter "C":

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

(2) **Case:** A household that HSD treats as a unit for purposes of eligibility determination; for example, a parent and child; a legal guardian and child; or a set of siblings.

(3) **Case management for physical health:** The case management programs that are part of the MAD benefit package. Case management programs are important service components. In these programs, case managers typically function independently and assess an eligible recipient's or his or her family's needs and strengths; develop a service/treatment plan; and coordinate, advocate for and link an eligible recipient to all needed services related to the case management program.

(4) **Claim:** A bill for services, a line item of service, or all services for one eligible recipient within a bill.

(5) **Claim dispute:** A dispute, filed by a MCO or SE service provider, involving payment of a claim, denial of a claim, or imposition of a sanction.

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

(7) **CoLTS:** The medical assistance division's coordination of long-term services program.

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

(9) **Community-based care:** A system of care that seeks to provide services to the greatest extent possible in or near the eligible recipient's home community.

(10) **Complaint:** An expression of dissatisfaction expressed by a complainant, orally or in writing, to the MCO, SE or to HSD or its designee about any matter related to the MCO or SE other than an action. Possible subjects for complaints include, but are not limited to, the quality of care or services provided; aspects of interpersonal relationships, such as rudeness of a service provider or employee; or failure to respect an eligible recipient's rights.

(11) **Concurrent review:** A process of updating clinical information from a service provider to a MCO or SE regarding an eligible recipient who is already receiving a covered service, to evaluate whether the service continues to be medically necessary.

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

(13) **Coordination of long-term services:** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers.

(14) **Copayment:** A monetary amount specified by the state that the eligible recipient pays directly to a MCO, SE or to a service provider at the time that covered services are rendered.

(15) **Critical incident:** A reportable incident involving an eligible recipient that may include, but is not limited to, abuse, neglect or exploitation; death; environmental hazards; law enforcement intervention; or emergency services, and which encompasses the full range of physical health, MAD state plan, and home and community-based services.

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

D. Definitions beginning with letter "D":

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

(2) **Denial, administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by MAD, or due to provider noncompliance with administrative policies and procedures established by either the MCO or SE or MAD.

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

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

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

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

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

E. Definitions beginning with letter "E":

(1) **Eligible recipient:** An individual who has been determined eligible for enrollment in a medical assistance program.

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

(3) **Encounter:** The record of a service rendered by a provider to a MCO or SE eligible recipient.

(4) **Encounter data:** Data elements from encounters for fee-for-service or capitated service proxy claims. Encounter data elements are a combination of those elements required by HIPAA-compliant transaction formats and other data elements that comprise a data set.

(5) **Eligible recipient rights:** Rights guaranteed by his or her MCO or SE.

(6) **Eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of the eligible recipient's individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Enhanced service:** Any service or benefit offered by the MCO or SE that is not included in the MAD benefit package or otherwise required by MAD and is not a MAD funded service, benefit or entitlement under the New Mexico Public Assistance Act. Also referred to as value added services.

(8) **Enrollment:** The process of enrolling an eligible recipient in a MCO or SE for purposes of management and coordination of health service delivery.

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

(10) **Exemption:** Removal of an eligible recipient from mandatory enrollment in coordination of long-term services, and placement in the MAD fee-for-service (FFS) program. Such action is only for substantial reason, as determined by HSD on a case-by-case basis.

(11) **Expedited appeal:** A federally mandated provision for an expedited resolution within three working days of the requested appeal, which includes an expedited review by the MCO or SE action.

(12) **External quality review organization (EQRO):** An independent organization with clinical and health services expertise capable of reviewing the evidence of compliance of health care delivery and internal quality assurance/improvement requirements.

F. Definitions beginning with letter "F":

(1) **Family-centered care:** When the child is the patient, the system of care reflects the importance of the family or legal guardian in the way services are planned and delivered. Family-centered care facilitates collaboration between family members and medical professionals, builds on individual and family strengths, and respects diversity of families.

(2) **Family planning services:** Services provided to male or female eligible recipients of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC, *Reproductive Health Services*).

(3) **Fee-for-service (FFS):** The traditional medicaid payment method whereby payment is made by HSD to a service provider after services are rendered and billed.

(4) **Federally qualified health center (FQHC):** An entity that meets the requirements and receives a grant and funding pursuant to Section 330 of the Public Health Service Act. An FQHC may include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (PL 93-638), or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act.

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

(6) **Full benefit dual eligible:** An individual enrolled in medicare and also is eligible for full MAD benefits.

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

G. Definitions beginning with letter "G":

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

(2) **Grievance, eligible recipient:** An oral or written statement by an eligible recipient expressing dissatisfaction with any aspect of a MCO or its operations but does not met the definition of "action" or "adverse determination".

(3) **Grievance, provider:** An oral or written statement by a provider to the CoLTS MCO/SE expressing dissatisfaction with any aspect of a MCO, SE or their operations but does not meet the definition of "action" or "adverse determination".

(3) **Grievance, provider:** An oral or written statement by a provider to a MCO expressing dissatisfaction with any aspect of a MCO, SE or MCO or SE or their operations but does not meet the definition of "action" or "adverse determination".

H. Definitions beginning with letter "H":

(1) **HCFA:** Health care financing administration. Effective 2001, the name was changed to centers for medicare and medicaid services (CMS).

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

(3) **Hearing or fair hearing:** An administrative hearing that is held so that evidence may be presented. (See 8.352.2 NMAC, *Recipient Hearings*.)

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

(5) **Hospitalist:** A physician employed by a hospital to manage the services of an eligible recipient admitted to the hospital for inpatient services.

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

I. Definitions beginning with letter "I":

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

(2) **Individualized service plan (ISP):** An individualized service plan developed with and for an eligible recipient who has chronic or complex conditions, and with others involved in the eligible recipient's services, to improve functional outcomes, including the standards in 8.314.2 NMAC, *Disabled and Elderly Home and Community Based Waiver*. An ISP includes, but is not limited to: an eligible recipient's history; a summary of current medical and social needs and concerns; short and long-term service needs and goals; a list of services required and their frequency; and a description of who will provide the services. An ISP must be in accordance with the approved CMS coordination of long-term services home and community-based waiver program and New Mexico MAD state plan.

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

J - K. [RESERVED]

L. Definitions beginning with letter "L": **Long-term services:** A continuum of services and supports for eligible recipients, ranging from in-home and community-based services for the elderly and eligible recipients with disabilities who need help in maintaining their independence, to institutional services for those who require an institutional level of support. Throughout the continuum of long-term services and supports, the goal is to provide needed services and supports to the eligible recipient while striving to maintain the eligible recipient's independence to the greatest extent possible.

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** A contracted organization licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of specified services to an enrolled eligible recipient. The MCO may be contracted specifically to provide physical health services to an eligible recipient entolled in

CoLTS as a CoLTS MCO or for behavioral health services as the single entity (SE) contracted to provide behavioral health services to an eligible recipient enrolled in CoLTS. A CoLTS MCO and the SE must each comply with the rules independently of each other.

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

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

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

(5) **Medically necessary services:**

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

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

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

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

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

(b) Application of the definition:

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

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

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

(iv) decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

(6) **Member or eligible recipient direction:** The ability of an eligible recipient to be actively involved in and in control of, to the extent possible, all aspects of his or her individual service plan (ISP); to identify and include others in the ISP planning process; and to hire and direct personal assistance services, as applicable.

(7) **Member month:** A calendar month during which an eligible recipient is enrolled in a MCO or SE.

(8) **Mi via home and community-based waiver:** The mi via waiver provides self-directed home and community based services (HCBS) to eligible HCBS waiver recipients who are disabled or elderly (D&E) now CoLTS (c), developmentally disabled (DD), medically fragile (MF), those diagnosed with acquired immunodeficiency syndrome (AIDS), and those diagnosed with certain brain injuries (BI).

N. Definitions beginning with letter "N":

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

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with a MCO or SE to furnish medical services to an eligible recipient enrolled in a MCO or SE under the provisions of the MAD CoLTS or SE contract.

(3) **Non-contracted provider (non-network provider):** An individual service provider, clinic, group, association or facility that provides covered services but does not have a contract with the MCO.

(4) **Nursing facility:** A medicare/MAD facility licensed and certified in accordance with 42 CFR 483 to provide inpatient room, board and nursing services to an eligible recipient who require these services on a continuous basis but who do not require hospital services or direct daily services from a physician.

O. [RESERVED]

P. Definitions beginning with letter "P":

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

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

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

(4) **Person-centered planning:** A process through which each eligible recipient is actively engaged, to the extent that the eligible recipient desires, in identifying their needs, goals and preferences, and in developing strategies to address those needs, goals and preferences.

(5) **Plan of care:** A written document including all medically necessary services to be provided by a MCO or SE for a specific eligible recipient.

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

(7) **Post-stabilization care services:** Services related to an emergency medical condition that are provided after an eligible recipient is medically stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 CFR Section 438.114(b) and (e) and 42 CFR Section 422.113(c)(iii) to improve or resolve the eligible recipient's condition.

(8) **Potential MCO or SE eligible recipient:** An eligible recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given CoLTS program but is not enrolled in a specific MCO or the SE.

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

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

(11) **Primary care:** All health services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, physician assistant or certified nurse practitioner.

(12) **Primary care case management (PCCM):** A medical care model in which an eligible recipient is assigned to a primary care provider who is responsible for managing the quality, appropriateness, and efficiency of the care the eligible recipient receives. The primary care provider is responsible for furnishing case management services to an eligible recipient that include the location, coordination, and monitoring of primary health care services and the appropriate referral to specialty care services.

(13) **Primary care case manager:** A physician, a physician group practice, an entity that an eligible recipient employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following:

(a) a physician assistant;
(b) a nurse practitioner; or
(c) a certified nurse midwife.

(14) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to an eligible recipient in a CoLTS program.

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

(16) **Provider lock-in, PCP lock-in:** A situation in which a MCO or SE requires that an eligible recipient see a specific identified network provider, while ensuring reasonable access to additional services, when the MCO or SE identifies utilization of unnecessary services or when an eligible recipient's behavior is detrimental or indicates a need to provide case continuity.

Q. Definitions beginning with letter "Q": **Quality assurance:** A process that is adopted by a health services entity that follows written standards and criteria. The process includes the activities of a health services entity or any of its committees that: investigate the quality of health services through the review of professional practices, home and community-based service provider practices, training and experience; investigate patient cases or conduct of licensed health service providers; or encourage proper utilization of health care services and facilities. Quality assurance follows a process of discovery, both prospective and retrospective to evaluate the program; identifies areas for remediation; and implements quality improvement strategies to ensure that appropriate and timely action is taken, as indicated.

R. Definitions beginning with letter "R":

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

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

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the eligible recipient's physical health (medical needs) or behavioral health (clinical needs) or long-term services needs.

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

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

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

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

S. Definitions beginning with letter "S":

(1) **Salud!:** The New Mexico physical health managed care program implemented in 1997, covering children, families, pregnant women and disabled New Mexicans.

(2) **Service coordination:** A specialized service management that is performed by a service coordinator, in collaboration with an eligible recipient or the eligible recipient's family member or a representative as appropriate, that is person-centered, and that includes, but is not limited to: (a) identification of the eligible recipient's needs, including physical health services, mental health services, social services, and long-term support services; and development of the eligible recipient's ISP or treatment plan to address those needs; (b) assistance to ensure timely and coordinated access to an array of providers and services; (c) attention to addressing unique needs of an eligible recipient; and (d) coordination with other services delivered outside the ISP, as necessary and appropriate. Service coordination operates independently within the MCO or SE using recognized professional standards adopted by the MCO or SE and approved by the state, based on the service coordinator's independent judgment to support the needs of the eligible recipient and is structurally linked to the other MCO or SE systems, such as quality assurance, eligible recipient services and grievances. Clinical and other decisions shall be based on medical necessity and not on fiscal considerations.

(3) **Service coordinator:** An employee or subcontractor of a MCO or SE with primary responsibility for providing service coordination/management to an eligible recipient who has complex care needs including long-term service and supports or needs, or who otherwise wants assistance with service planning. The service coordinator need not be a medical professional.

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

(5) **Special needs individual:** A medicare advantage (MA) eligible individual who is institutionalized, is entitled to medical assistance under a state plan under Title XIX, or has a severe or disabling chronic condition(s) and would benefit from enrollment in a specialized MA plan.

(6) **Special needs plan:** A specialized MA coordinated service plan for special needs individuals that exclusively or disproportionately serves special needs individuals.

(7) **State plan:** A statewide plan for MAD eligibility and services submitted for approval to CMS under Title XIX of the federal Social Security Act.

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

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

(10) **Suspension or suspended provider:** A service provider that has been convicted of a program-related offense in a federal, state or local court. Items or services furnished by a suspended provider will not be reimbursed under MAD.

T. Definitions beginning with letter "T":

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

(2) **Third party:** An individual entity or program that is or may be, liable to pay all or part of the expenditures for an eligible recipient's services.

(3) **Tribal facility 638:** A facility operated by a Native American or Indian tribe authorized to provide services pursuant to the Indian Self-Determination and Education Assistance Act.

(4) **Tribal provider or Indian health service (IHS) provider:** A facility that is operated by a Native American/Alaskan Indian tribe authorized to provide services as defined in the Health Care Improvement Act, 25 USC Section 1601, et seq.

U. Definitions beginning with letter "U":

(1) **Urgent condition:** Acute signs and symptoms that, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

(2) **Utilization management:** A system for reviewing the appropriate and efficient allocation of health care services given or proposed to be given to a member.

V. [RESERVED]

W. Definitions beginning with letter "W": **Waiver program:** One or more of the state of New Mexico MAD home and community-based services waiver programs.

X - Z. [RESERVED]

[8.307.1.7 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

8.307.1.8 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.

[8.307.1.8 NMAC - N, 8-1-08; A, 9-1-09; A, 10-15-12]

HISTORY OF 8.307.1 NMAC: [RESERVED]