INDEX

8.305.8 QUALITY MANAGEMENT

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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 8 QUALITY MANAGEMENT

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

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

8.305.8.3 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).
[8.305.8.3 NMAC - N, 7-1-01]

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

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

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

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

8.305.8.8 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.
[8.305.8.8 NMAC - N, 7-1-01, A, 7-1-09]

8.305.8.9 QUALITY MANAGEMENT: Quality management is both a philosophy and a method of management designed to improve the quality of services; includes both quality assurance and quality improvement activities; and, is incorporated into health care delivery and administrative systems.
[8.305.8.9 NMAC - Rp 8 NMAC 4.MAD.606.7, 7-1-01; A, 7-1-04; A, 7-1-09]

8.305.8.10 EXTERNAL QUALITY REVIEW: HSD shall retain the services of an external quality review organization (EQRO) in accordance with Section 1902 (a) (30) [C] of the Social Security Act. The managed care organizations (MCOs)/single statewide entity (SE) shall cooperate fully with the EQRO. The EQRO shall not be a competitor of the MCO.
[8.305.8.10 NMAC - Rp 8 NMAC 4.MAD.606.7.1, 7-1-01; A, 7-1-05]

8.305.8.11 BROAD STANDARDS:

A. **NCQA requirement:** The MCO shall have and maintain national committee for quality assurance (NCQA) accreditation for its medicaid product line. If the MCO is not so accredited, it will actively pursue such accreditation. NCQA accreditation is not required for the SE.

(1) An MCO with NCQA national accreditation shall provide HSD with a copy of its current certificate of accreditation, a copy of any accreditation review/revision of accreditation status and a copy of the NCQA survey report for the medicaid product line.

(2) A non-accredited MCO must provide a copy of the NCQA/national accreditation confirmation letter indicating the date for the site visit.

B. **HEDIS requirement:** The MCO shall submit a copy of its audited healthcare effectiveness data and information set (HEDIS) data submission tool and the results of the MCO's HEDIS Compliance Audit ™ to

HSD or its designee at the same time it is submitted to NCQA. The MCO is expected to use and rely upon HEDIS data as an important measure of performance for HSD. The MCO is expected to use HEDIS data as a measure of performance and to incorporate the results of each year's HEDIS data submission into its QI/QM plan.

C. **Mental health reporting requirement:** The SE shall collect and submit a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey to include the medicaid adult and child family population annually. The annual C/FSP survey shall be conducted on a calendar year basis and shall include non-survey indicators defined by HSD each contract calendar year. The SE shall submit to HSD a written analysis of the annual C/FSP report for medicaid based on the aggregate survey data results for both the child/family and adult medicaid populations.

D. **Collection of clinical data:** The MCO/SE shall collect clinical data utilizing a sample of clinical records sufficient to produce statistically valid results. The sample shall support stratification of the population served.

E. **Behavioral health data (SE only):** For reporting purposes, BH data for medicaid managed care members shall include all behavioral health services regardless of setting or location. Data shall be collected and reported as required to HSD.

F. **Provision of emergency services:** The MCO shall ensure that acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the "anti-dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act). The SE shall ensure that the UNM psychiatric emergency room is reimbursed for emergency services provided.

G. **Disease reporting:** The MCO/SE shall require its providers to comply with the disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

H. **Other required reporting:** The MCO/SE agrees to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et seq. and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et seq. Any violation of this provision shall be reported to the HHS and the appropriate regional office of the environmental protection agency.

[8.305.8.11 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** The MCO/SE's quality management (QM) and improvement (QI) structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements; responsibilities shall be assigned to appropriate individuals. Internal processes shall be transparent and accountable. The MCO/SE's QM/QI activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review (EQR) annual evaluation, annual HEDIS indicators, state defined performance measures and consumer satisfaction surveys and provider surveys.

(1) The QM/QI program shall include: specific targeted goals, objectives and structure that cover the MCO/SE's immediate objectives for each contract year or calendar year, and long-term objectives for the entire contract period. The annual plan shall include the specific interventions to be utilized to improve the quality targets, as well as, the timeframes for evaluation.

(2) Internal processes shall be transparent and accountable; processes shall reflect policies and procedures and activities shall be documented.

(3) The program description shall address QM/QI for all major demographic groups within the MCO/SE.

(4) The QM/QI description or work plan shall address the process by which the MCO/SE adopts reviews, updates and disseminates evidence-based clinical practice guidelines for provision of services for acute and chronic conditions, including behavioral health (SE only). The MCO/SE shall involve its providers in this process.

(5) The program description or work plan shall address activities to improve health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing providers about the programs and services for members assigned to them.

(6) The annual written evaluation shall include a review of completed and continuing quality improvement activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service.

B. **Program operations:** The QM/QI committee shall:

(1) review and evaluate the results of quality improvement activities, institute needed action and

ensure follow-up, as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all QM/QI committee decisions and actions;

(3) ensure that the MCO/SE shall coordinate the QM/QI program with performance monitoring activities throughout the organization, including but not limited to, utilization management, fraud and abuse detection, credentialing, monitoring and resolution of member grievances and appeals, assessment of member satisfaction and medical records review; and

(4) ensure that the results of QM/QI activities, performance improvement projects and reviews are used to improve quality.

C. **Health services contracting:** Contracts with individual and institutional providers shall specify compliance with the MCO/SE's QM/QI program.

D. **Continuous quality improvement/total quality management:** The MCO/SE shall ensure that both clinical and nonclinical aspects of the MCO/SE quality management program shall be based on principles of continuous quality improvement/total quality management (CQI/TQM). Such an approach shall include at least the following:

(1) recognition that opportunities for improvement are unlimited;

(2) be data driven;

(3) use real-time member and provider input to develop CQI activities; and

(4) require on-going measurement of clinical and non-clinical effectiveness and programmatic improvements.

E. **Member satisfaction:** The MCO/SE shall ensure results of member satisfaction surveys are used to improve quality.

(1) The MCO/SE shall evaluate member grievances and appeals for trends and specific problems.

(2) The MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement.

(3) The MCO/SE shall implement interventions and measure the effectiveness of these interventions.

(4) The MCO/SE shall inform members, providers and HSD of the results of member satisfaction activities as specified by HSD.

F. **Health management systems:**

(1) The MCO/SE shall actively work to improve the health status of its members with chronic physical and behavioral health conditions, utilizing best practices throughout the MCO/SE's provider networks.

(a) The MCO shall proactively identify members with chronic medical conditions, and offer appropriate outreach, services and programs to assist in managing and improving their chronic conditions. The SE shall proactively identify members with chronic behavioral health conditions and offer appropriate outreach, services and programs to assist in managing and improving their chronic behavioral health patient outcomes.

(b) The MCO/SE shall proactively identify individuals with special health care needs who have or are at increased risk for a chronic physical or behavioral health condition.

(c) The MCO/SE shall inform and educate its providers about using the health management programs for the members.

(d) The MCO/SE shall facilitate, through their committee structure, a process for identifying and addressing the appropriate use of psychopharmacological medications and adverse drug reactions.

(2) The MCO/SE shall pursue continuity of care for members.

(a) The MCO/SE shall have a defined process to ensure prompt member notification by its providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing and this will be documented in the medical record.

(b) The MCO/SE shall ensure that the processes for follow-up visits, consultations and referrals are consistent with high quality care and service and do not create a clinically significant impediment to timely medically necessary services. The determination of medical necessity shall be based on HSD's medical necessity definition and its application.

(c) The MCO/SE shall develop a policy and procedure that addresses the education of the member and promotes compliance with follow up appointments, consultation/referrals and diagnostic laboratory, imaging and other testing.

G. **Clinical practice guidelines:** The MCO/SE shall disseminate recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services.

(1) The MCO/SE shall select the clinical issues to be addressed with clinical guidelines based on the

needs of the medicaid populations.

(2) The clinical practice guidelines shall be evidence-based.

(3) The MCO/SE shall involve board certified providers from its network who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

(4) The MCO/SE shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two years, and updating them as necessary.

(5) The MCO/SE shall distribute the guidelines to the appropriate providers and, upon request, to HSD.

(6) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

(7) The MCO/SE shall implement targeted disease management protocols for chronic diseases or conditions that are appropriate to meet the needs of the varied medicaid populations.

H. **Quality assessment and performance improvement:** The MCO/SE shall achieve required minimum performance levels on performance measures, as established by HSD. The quality measures may be used in part to determine the MCO assignment algorithm.

(1) Disease management/performance measures shall be identified at the beginning of each contract year by HSD.

(2) The MCO/SE shall measure its performance, using claims, encounter data and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD.

I. **Effectiveness of the QM/QI program:** The MCO/SE shall evaluate the overall effectiveness of its QM/QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members. An annual written evaluation, submitted to HSD, shall include a description of completed and ongoing quality improvement activities; trending of measures; and, analysis of demonstrated improvement of identified opportunities for improvement.

[8.305.8.12 NMAC - Rp 8 NMAC 4.MAD.606.7.2, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: The MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria congruent with HSD's medical necessity service definition. The MCO/SE shall request approval from HSD of all UM and level of care criteria. Utilization management (UM) standards shall be applied consistently so services are provided in a coordinated fashion with neither over nor under-utilization. The MCO/SE's utilization management program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to authorize services through fair, consistent and culturally competent decision making to assure equitable access to care. These standards shall also apply to pharmacy utilization management including the formulary exception process. Services provided within the IHS and tribal 638 networks are not subject to prior authorization requirements, except for behavioral health residential treatment center (RTC) services.

A. **Program design:**

(1) A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the MCO and entities to which the MCO/SE delegates UM activities.

(2) A designated physician and a behavioral health care physician for the SE shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate care coordination, discharge criteria, levels of care, triage decisions and cultural competence of care delivery; processes to review, approve and deny services; and processes to evaluate service outcomes; and including a plan to improve outcomes, as needed.

(4) The UM program shall be evaluated and approved annually by senior management and the medical (or behavioral health) director or the QI committee.

(5) The UM program shall include policies and procedures for monitoring inter-rater reliability of all individuals performing UR review. The procedures shall include a monitoring and education process for all UR staff identified as not meeting 90 percent agreement on test cases, until adequately resolved.

B. **UM decision criteria:** The MCO/SE shall use written utilization review decision criteria that are based on reasonable medical evidence, consistent with the New Mexico medicaid definition for medically necessary services, and that are applied in a fair, impartial and consistent manner The MCO/SE shall ensure that the services

are no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230. The MCO/SE may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the beneficiary's diagnosis, type of illness or condition.

(2) The criteria for determining medical necessity shall be academically defensible. The MCO/SE shall specify what constitutes medically necessary services in a manner that is no more restrictive than that used by HSD. The MCO/SE must be responsible for covered services related to:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

(3) Criteria for determination of medical appropriateness shall be clearly documented.

(4) The MCO/SE shall maintain evidence that the criteria has been reviewed and updated at specified intervals.

(5) The MCO/SE shall state in writing how practitioners can obtain UM criteria and shall provide criteria to its practitioners upon request. The MCO/SE shall have written policies and procedures describing how health professionals may access the clinical information used to support UM decisions and the specific clinical information that a provider must make available to an MCO to support a UM decision.

C. **Authorization of services:** The MCO/SE shall:

(1) have a policy and procedure in place for authorization requests and decisions;

(2) require subcontractors have written policies and procedures for authorization requests and decisions;

(3) ensure consistent application of review criteria for authorization decisions; and

(4) consult with requesting providers when appropriate.

D. **Use of qualified professionals:** The MCO/SE shall utilize appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews and are qualified to supervise review decisions. Denials based on medical necessity shall be made by a designated physician for the UM program. The reason for the denial shall be cited.

E. **Timeliness of decisions and notifications:** The MCO/SE shall make utilization decisions and notifications in a timely manner that accommodates the clinical urgency of the situation and shall minimize disruption in the provision and continuity of health care services. The following time frames are required and shall not be affected by "pend" decisions.

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) care, the MCO/SE shall make a decision within 14 calendar days from receipt of request for service.

(b) **Notification:** For authorization or denial of non-urgent (routine) care, the MCO/SE shall notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) care, the MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision.

(2) **Precertification - urgent:**

(a) **Decision and notification:** For precertification of urgent care, the MCO/SE shall make a decision and notify the provider of the decision within 72 hours of receipt of request. For authorization of urgent care that results in a denial, the MCO/SE shall notify both the member and provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent care, the MCO/SE shall give the member and provider written or electronic confirmation of the decision within two working days of making the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(3) **Precertification - residential services (SE only):** For precertification of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent care, a 14 calendar day extension may be requested by the member or provider. A 14 calendar day extension may also be requested by the MCO/SE. The MCO/SE must justify in the UM file the need for additional information and that the 14 day extension is in the member's interest.

(5) **Concurrent - routine:**

(a) **Decisions:** For concurrent review of routine services, the MCO/SE shall make a decision within 10 working days of the receipt of the request.

(b) **Notification:** For authorization or denial of routine continued stay, the MCO/SE shall

notify a provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(6) **Concurrent - urgent:**

(a) **Decision:** For concurrent review of urgent services, the MCO/SE shall make a decision within one working day of receipt of request.

(b) **Notification:** For authorization or denial of urgent continued stay, the MCO/SE shall notify a provider of the decision within one working day of making the decision. The MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the MCO/SE shall give the member and provider written or electronic confirmation within one working day of the decision. The MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(7) **Concurrent - residential services (SE only):** For concurrent reviews of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service. Timelines for routine and urgent concurrent shall apply.

(8) **Administrative/technical denials:** When the MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to provider noncompliance with the MCO/SE's administrative policies, the MCO/SE shall adhere to the timelines cited above for decision making, notification and written confirmation.

F. **Use of clinical information:** When making a determination of coverage based on medical necessity, the MCO/SE shall obtain relevant clinical information and consult with the treating practitioner, as appropriate.

(1) A written description shall identify the information required and collected to support UM decision making.

(2) A thorough assessment of the member's needs based on clinical appropriateness and necessity shall be performed.

(3) There shall be documentation that relevant clinical information is gathered consistently to support UM decision making. The MCO/SE UM policies and procedures will clearly define in writing for providers what constitutes relevant clinical information.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating providers.

G. **Denial of services:** A "denial" is a non-authorization of a request for care or services. The MCO/SE shall clearly document in the UR file a reference to the provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

(1) The MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease, such as the MCO/SE medical director.

(2) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the MCO/SE shall deny that which was determined to be inappropriate, and provide an appropriate alternative level of care (setting) which would be covered.

(3) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner.

(4) The MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.

(5) The MCO/SE shall make available to a requesting provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

(6) The MCO/SE shall recognize that a utilization review decision made by the designated HSD official resulting from a fair hearing is final and shall be honored by the MCO/SE, unless the MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each MCO/SE contract must provide that, consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary

services to any member.

I. **Evaluation and use of new technologies:** The MCO/SE and its delegates shall evaluate the inclusion of new medical technology and the new applications of existing technology in the benefit package. This includes the evaluation of clinical procedures and interventions, drugs and devices.

(1) The MCO/SE shall have a written description of the process used to determine whether new medical technology and new uses of existing technologies shall be included in the benefit package.

(a) The written description shall include the decision variables used by the MCO/SE to evaluate whether new medical technology and new applications of existing technology shall be included in the benefit package.

(b) The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

(c) Appropriate professionals shall participate in the process to decide whether to include new medical technology and new uses of existing technology in the benefit package.

(2) An MCO/SE shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of "experimental, investigational or unproven" contained in 8.325.6 NMAC, *Experimental or Investigational Procedures, Technologies or Therapies*.

J. **Evaluation of the UM process:** The MCO/SE shall evaluate member and provider satisfaction with the UM process based on member and provider satisfaction survey results. The MCO/SE shall forward the evaluation results to HSD.

K. **HSD access:** HSD shall have access to the MCO/SE's UM review documentation on request.

[8.305.8.13 NMAC - Rp 8 NMAC 4.MAD.606.7.4, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The MCO/SE shall document the mechanism for credentialing and recredentialing of providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority The documentation shall include, but not be limited to, defining the scope of providers covered, 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 recredentialing arrangements. The credentialing process shall be completed within 45 days from receipt of completed application with all required documentation unless there are extenuating circumstances. The MCOs shall all use the same 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/SE shall have a process for receiving input from participating providers regarding credentialing and recredentialing of providers.

B. **Primary source verification:** The MCO/SE shall verify the following information from primary sources during credentialing:

(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 providers, 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 the practitioner is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the MCO/SE's 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/SE shall use the HSD-approved credentialing form. The provider shall complete a credentialing application that includes a statement by the applicant 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/SE 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) HHS/OIG exclusion from participation in 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; sanctions by medicare, medicaid, the state children's health insurance program or any federal care program.

E. **Evaluation of practitioner site and medical records.** The MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists and the SE shall perform an initial visit to the offices of potential high volume behavioral health care practitioners, prior to acceptance and inclusion as participating providers. The MCO/SE shall determine its method for identifying high volume behavioral health practitioners.

(1) The MCO/SE shall document a structured review to evaluate the site against the MCO's organizational standards and those specified by the managed care contract.

(2) The MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the MCO/SE's organizational standards.

F. **Recredentialing:** The MCO/SE shall have formalized recredentialing procedures.

(1) The MCO/SE shall recredential its providers at least every three years. The MCO/SE shall verify the following information from primary sources during recredentialing:

(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 recredentialed;

(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 recredentialing 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 practitioner types;

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

(j) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance program and all federal health care programs.

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

(a) member grievances and appeals;

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

(c) medical record reviews conducted under Subsection E of 8.305.8.14 NMAC.

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

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

H. **Assessment of organizational providers:** The MCO/SE 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/SE 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) DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) 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 on accreditation of healthcare organizations (JCAHO); 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.

[8.305.8.14 NMAC - Rp 8 NMAC 4.MAD.606.7.5, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.15 MEMBER BILL OF RIGHTS: The MCO/SE shall have policies and procedures governing member rights and responsibilities and require adherence by all providers, including MCO-contracted providers. The following subsections shall be known as the "Member Bill of Rights".

A. **Members' rights:**

(1) Members shall have the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Members shall have the right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have the right to participate with their health care providers in decision making in all aspects of their health care, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with care decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the MCO/SE network, or the MCO/SE shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian needs additional information regarding recommended treatment or believes the

provider is not authorizing requested care.

(8) Members or their legal guardians shall have a right to voice grievances about the care provided by the MCO/SE and to make use of the MCO/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have the right to choose from among the available providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have the right to make their wishes known through advance directives regarding health care decisions (e.g., living wills, right to die directives, "do not resuscitate" orders, etc.) consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have the right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have the right to receive information about: the MCO/SE, its health care services, how to access those services, and the MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the MCO/SE or its network providers in regard to contractual disputes between the MCO/SE and providers.

(14) Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or state of New Mexico regulations on the use of restraints and seclusion.

(15) (MCO only) Members or their legal guardians shall have the right to select an MCO and exercise switch enrollment rights without threats or harassment.

B. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have the responsibility to provide, whenever possible, information that the MCO/SE and providers need in order to care for them.

(2) Members or their legal guardians shall have the responsibility to understand the member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have the responsibility to follow the plans and instructions for care that they have agreed upon with their providers or to notify providers if changes are requested.

(4) Members or their legal guardians shall have the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

C. **MCO/SE responsibilities:**

(1) The MCO/SE shall provide a member handbook to its members and to potential members who request the handbook and have the handbook accessible via the internet. The MCO/SE shall publish the members' rights and responsibilities from the member bill of rights in the member handbook. MCOs/SE shall honor the provisions set forth in the member bill of rights.

(2) The MCO/SE shall comply with the grievance resolutions process delineated in 8.305.12 NMAC, *MCO Member Grievance System*.

(3) The MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) requires no more than a two-minute wait except following mass enrollment periods;

(b) does not require a "touch-tone" telephone;

(c) allows communication with members whose primary language is not English or who are hearing impaired; and

(d) is in operation 24 hours per day, seven days per week.

(5) The MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The MCO/SE shall protect the confidentiality of member information and records.

(a) The MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The MCO/SE's contracts with providers shall explicitly state expectations about

confidentiality of member information and records.

(c) The MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the MCO/SE of identifiable personal information to a person or agency outside the MCO/SE, except when release is required by law, state regulation, court order or HSD quality standards. HSD shall only use this information consistent with the requirements listed in 45 CFR 164.508.

(d) The MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the MCO/SE delegates member service activity, the MCO/SE shall retain responsibility for documenting MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to providers within the MCO/SE network. The MCO/SE shall have written policies regarding the requirement for providers to abide by federal and state law and New Mexico medicaid policies regarding informed consent specific to:

(a) the treatment of minors;

(b) adults who are in the custody of the state;

(c) adults who are the subject of an active protective services case with CYFD;

(d) children and adolescents who fall under the jurisdiction of CYFD; and

(e) individuals who are unable to exercise rational judgment or give informed consent consistent with federal and state laws and New Mexico medicaid regulations.

(9) The MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The MCO/SE shall ensure that its providers and their facilities comply with the Americans with Disabilities Act.

(10) The MCO/SE shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

(11) The MCO shall not restrict a member's right to choose a provider of family planning services.

(12) The MCO/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.305.8.15 NMAC - Rp 8 NMAC 4.MAD.606.7.6, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The MCO shall follow current national standards for preventive health services including behavioral health preventive services. Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the MCO under these standards shall be adopted [~~,~~] and reviewed at least every two years, updated when appropriate and disseminated to practitioner and member. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access care.

A. **Initial assessment:** The MCO shall perform an initial assessment of the medicaid member's health care needs within 90 days of the date the member enrolls in the MCO. For this purpose, a member is considered enrolled at the lock-in date. This assessment must include a question regarding the member's primary language spoken and written.

B. **Immunizations:** The MCO shall adopt policies that to the extent possible, ensure that within six months of enrollment, members are immunized according to the type and schedule provided by current recommendations of the state department of health. The MCO shall encourage providers to verify and document all administered immunizations in the New Mexico statewide immunization information system (SIIS).

C. **Screens:** The MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium, at a periodicity determined by the MCO.

(4) *Blood pressure measurement*: Members over age 18 shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam. Children shall receive a BMI percentile designation.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

(9) *Screening for rubella*: All female members of childbearing ages shall be screened for rubella susceptibility by history of vaccination or by serology.

(10) *Screening for chlamydia*: All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier contraception, have more than one sex partner, or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over nine lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The MCO shall operate tot-to-teen mandated early and periodic screening, diagnostic and treatment (EPSDT) services as outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within three months of enrollment lock-in, the MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards). The MCO shall encourage PCPs to assess and document for age, height and gender appropriate weight and for BMI percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in children and adolescents.

(15) Members over age 21 must be screened to detect high risk for behavioral health conditions at their first encounter with a PCP after enrollment.

(16) The MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;
(2) benefits of physical activity;
(3) benefits of a healthy diet;
(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;
(5) prevention of motor vehicle injuries;
(6) prevention of household and recreational injuries;
(7) prevention of dental and periodontal disease;
(8) prevention of HIV infection and other sexually transmitted diseases;
(9) prevention of unintended pregnancies; and
(10) prevention or intervention for obesity or weight issues.

E. **Hot line:** The MCO/SE shall provide a toll-free clinical telephone hot line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and
(2) prediagnostic and post-treatment health care decision assistance based on symptoms.

F. **Health information line:** The MCO shall provide a toll-free line that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions; and
(2) preventive/wellness counseling.

G. **Family planning:** The MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and
(2) HIV and other sexually transmitted diseases and risk reduction practices.

H. **Prenatal care:** The MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;
(2) prompt and easy access to obstetrical care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;
(3) risk assessment of all pregnant members to identify high-risk cases for special management;
(4) counseling that strongly advises voluntary testing for HIV;
(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;
(6) screening for determination of need for a post-partum home visit; and
(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.305.8.16 NMAC - Rp 8 NMAC 4.MAD.606.7.7, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, and be legible, current, detailed and organized to permit effective and confidential patient care and quality review.

(1) The MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The MCO/SE shall have medical record documentation standards that are enforced with its MCO/SE providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);
(b) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;
(d) provider identification (author of entry);
(e) allergies and adverse reactions to medications;
(f) past medical history for patients seen two or more times;
(g) status of preventive services provided or at least those specified by HSD, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;
(h) diagnostic information;
(i) medication history including what has been effective and what has not, and why;
(j) identification of current problems;
(k) history of smoking, alcohol use and substance abuse;
(l) reports of consultations and referrals;
(m) reports of emergency care, to the extent possible;
(n) advance directive for adults; and
(o) record legibility to at least a peer of the author.

(3) For SE behavioral health patients, documentation shall include all elements listed above in addition to the following:

(a) a mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;
(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;
(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;
(d) documentation of progress toward attainment of the goal; and
(e) preventive services such as relapse prevention and stress management.

(4) The MCO/SE standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;
(b) plan of treatment;
(c) diagnostic tests and the results;
(d) drugs prescribed, including the strength, amount, directions for use and refills;
(e) therapies and other prescribed regimens and the results;
(f) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);
(g) consultations and referrals and the results; and
(h) any other significant aspect of the member's physical or behavioral health care.

B. **Review of records:** The MCO/SE shall have a process to systematically review provider medical records to ensure compliance with the medical record standards. The MCO/SE shall institute improvement and actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the MCO's primary care providers, obstetricians, and gynecologists. The EQRO shall conduct a review of a representative sample of clinical records from the SE's behavioral health providers to determine compliance with the SE's established medical record standards and goals.

(2) The MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site compliance with the MCO/SE's established medical record standards and goals.

C. **Access to records:** The MCO/SE shall provide HSD or its designee appropriate access to provider medical records.

(1) The MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all providers involved in the member's care, to ensure continuity of care. The MCO shall ensure that providers involved in the member's care have access to the member's primary medical record including the SE, when necessary.

(2) The MCO/SE shall include provisions in its contracts with providers for appropriate access to the MCO/SE's members' medical records for purposes of in-state quality reviews conducted by HSD or its designee, and for making medical records available to physical health and behavioral health care providers.

(3) The MCO shall have a policy that ensures the confidential transfer of medical and dental

information when a primary medical or dental provider leaves the MCO, the member changes primary medical or dental practitioner or after a member changes enrollment from one MCO to another MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another when a provider leaves the SE network or the member changes behavioral health provider or practitioner.

(5) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one collaborative agency to another.

(6) The MCO/SE shall forward health information from the provider's medical records to HSD or its designee, as requested.

[8.305.8.17 NMAC - Rp 8 NMAC 4.MAD.606.7.8, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to health care providers for each medically necessary service. The MCO/SE 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 shall be offered.

B. **Access to urgent and emergency services:** Services for emergency conditions provided by physical 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). The SE shall coordinate all behavioral health transportation with the member's respective MCO. 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 children and adolescents 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, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member. 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/SE shall ensure that there is no clinically significant delay caused by the MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The MCO/SE 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-emergency in nature.

(2) The MCO/SE 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/SE.

(3) The MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The MCO shall follow a process that ensures a sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The MCO shall have at least one primary care provider available per 1,500 members and no more than 1,500 members assigned to a single provider unless approved by HSD.

(2) The minimum number of primary care providers 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 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.

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

(1) 90 percent of urban residents shall travel no farther than 30 miles;
(2) 90 percent of rural residents shall travel no farther than 45 miles; and
(3) 90 percent of frontier residents shall travel no farther than 60 miles.

E. **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. The SE shall 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.

(1) The MCO shall report to HSD all provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members. The SE shall report to HSD all individual providers, provider groups, provider agencies or facilities and corresponding sites in its network that are not accepting new medicaid members.

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

(3) (MCO only) For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) (MCO only) For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) (SE only) For nonurgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) (MCO/SE) Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours.

(7) (MCO only) For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) (MCO only) 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 days, unless the member requests a later time.

(9) (MCO only) 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.

(10) (MCO only) 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.

(11) (MCO/SE) The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a practitioner shall be filled within 90 minutes.

(12) (MCO/SE) The timing of scheduled follow-up outpatient visits with practitioners shall be consistent with the clinical need.

(13) The MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.305.7.11 NMAC, *Services Included in the Salud! Benefit Package, Pharmacy Services*.

(15) 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.

(a) 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 days of the request date.

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

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

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

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

(16) 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:

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

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

(c) subject to any requirements to procure a physician's order to provide supplies to the member, 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.

(17) The MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the MCO/SE or its subcontractor.

F. **Access to transportation services:** The MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The MCO shall coordinate behavioral health transportation services with the SE. The MCO shall have sufficient transportation providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant 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) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.305.8.18 NMAC - Rp 8 NMAC 4.MAD.606.7.9, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.8.19 DELEGATION: Delegation is a process whereby an MCO/SE gives another entity the authority to perform certain functions on its behalf. The MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The MCO/SE shall document its oversight of the delegated activity. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD.

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

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

(2) the delegated activity;

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

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

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

B. The MCO/SE shall document evidence that the MCO/SE:

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

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

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

[8.305.8.19 NMAC - N, 7-1-01; A, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

HISTORY OF 8.305.8 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
Rp, 8 NMAC 4.MAD.606.7
8 NMAC 4.MAD.606.7, Managed Care Policies, Quality Management, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.7, Managed Care Policies, Quality Management - Repealed, 7-1-01.