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8.305.9 COORDINATION OF SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 9 COORDINATION OF SERVICES

8.305.9.1 ISSUING AGENCY: Human Services Department
[8.305.9.1 NMAC - Rp 8.305.9.1 NMAC, 7-1-04]

8.305.9.2 SCOPE: This rule applies to the general public.
[8.305.9.2 NMAC - Rp 8.305.9.2 NMAC, 7-1-04]

8.305.9.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.9.3 NMAC - Rp 8.305.9.3 NMAC, 7-1-04]

8.305.9.4 DURATION: Permanent
[8.305.9.4 NMAC - Rp 8.305.9.4 NMAC, 7-1-04]

8.305.9.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.9.5 NMAC - Rp 8.305.9.5 NMAC, 7-1-04]

8.305.9.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.9.6 NMAC - Rp 8.305.9.6 NMAC, 7-1-04]

8.305.9.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.9.7 NMAC - Rp 8.305.9.7 NMAC, 7-1-04]

8.305.9.8 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.
[8.305.9.8 NMAC - Rp 8.305.9.8 NMAC, 7-1-04; A, 7-1-09]

8.305.9.9 COORDINATION OF SERVICES:

A. The MCO/SE shall develop and implement policies and procedures to ensure access to care coordination for individuals with special health care needs (ISHCN) as defined in 8.305.15.9 NMAC, *Services for Individuals with Special Health Care Needs (ISHCN).* Care coordination is defined as an office-based administrative function to assist members at risk for adverse outcomes to help meet their needs by filling the gaps in current health care on an as needed basis. Care coordination is member-centered, consumer-directed and family-focused, culturally competent, strengths-based and ensures that medical and behavioral health needs are identified. Services are provided and coordinated with the member and family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; monitoring outcomes and resource use; coordinating visits with subspecialists; organizing care to avoid duplication of diagnostic tests and services; sharing information among health care professionals and family; facilitating access to services; actively managing transition of care such as hospital discharge; training caregivers; and ongoing reassessment and refinement of the care plan. Care coordination can help to ensure that the physical and behavioral health needs of the medicaid population are identified and services are provided and coordinated with all service providers, individual members and family, if appropriate, and authorized by the member. Care coordination operates within the MCO/SE with a dedicated care coordination staff functioning independently, but is structurally linked to the other MCO/SE systems, such as quality assurance, member services and grievances. Care coordination is not “gate keeping” or “utilization management”. Clinical decisions shall be based on the medically necessary covered services and not fiscal considerations. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute. The MCO/SE responsible for the care of the most acute condition shall be primary lead on care coordination activities with necessary assistance and collaboration from both entities. Care shall be coordinated

between both physical health MCO staff and behavioral health SE staff. The MCO/SE shall conduct the following system processes for care coordination:

(1) identify proactively the eligible populations;

(2) identify proactively the needs of the eligible population;

(3) provide a designated person to be primarily responsible for coordinating the health services furnished to a specific member and to serve as the single point of contact for the member; and

(4) ensure access to care coordination for all medicaid eligible ISHCN, as required by federal regulations.

B. The care coordinator shall be responsible for the following activities:

(1) communicate to the member the care coordinator's name and how to contact this person;

(2) ensure and coordinate access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan as per applicable provider regulations;

(3) ensure appropriate coordination between physical and behavioral health services and non-managed care services; and, in the case of the SE, also coordinate care among other applicable agencies in the collaborative;

(4) coordinate the needs and identify the status of co-managed cases with either the MCO physical health care coordinator or the SE behavioral health care coordinator;

(5) monitor progress of members to ensure that medically necessary services are received, to assist in resolving identified problems, and to prevent duplication of services;

(6) (SE ONLY) coordinate the provision of necessary services and actively assist members in obtaining such services when a local community case manager is not available;

(7) (SE ONLY) develop a member's individual plan of care (care coordination plan) with involvement from the member and family/guardian (as appropriate) based on a comprehensive assessment of the goals, capabilities and the behavioral health service needs of the member and with consideration of the needs and goals of the family (if appropriate); provide for an evaluation process of the plan that measures the member's response to care and ensures revision of the plan as needed;

(8) (MCO ONLY) ensure the development of a member's individual plan of care, based on a comprehensive assessment of the goals, capabilities and medical condition of the member and with consideration of the needs and goals of the family; provide for an evaluation process that measures the member's response to care and ensures revision of the plan as needed;

(9) involve the member and family in the development of the plan of care, as appropriate; a member or family shall have the right to refuse care coordination or case management, that will be documented in the care coordination file; and

(10) verify that all necessary information is shared with key providers to facilitate the delivery of optimum care; the MCO/SE shall ensure and document that the releasing provider has obtained either written or documented verbal permission from the member for the release of information; this information sharing is required communication between primary care and behavioral health care, as well as among involved behavioral health providers and across other service providing systems.

C. For clarification purposes, activities provided through care coordination at the MCO/SE level differ from case management activities provided as part of the targeted case management programs included in the medicaid benefit package. These external case management programs shall continue to be important service components delivered as a portion of the medicaid benefit package.

[8.305.9.9 NMAC - Rp 8.305.9.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.10 COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH SERVICES BENEFITS:

A. **Coordination of physical and behavioral health services:** Physical and behavioral health services shall be provided through a clinically coordinated system between the MCO and SE. The MCO and SE shall coordinate a member's care with one another, if the member has both physical and behavioral health needs. Both physical and behavioral health care providers would benefit from having access to relevant medical records of mutually-served members to ensure the maximum benefit of services to the member. The MCO and the SE shall develop and share policies and procedures to ensure effective care coordination across systems as authorized by the member. Both contractors shall be responsible for monitoring the effectiveness of referrals and coordinating with multiple providers and for the process of information sharing between the physical and behavioral health care providers. The MCO/SE shall have defined processes for coordinating complex physical and behavioral health

cases, which include participation of its medical directors. Confidentiality and HIPAA regulations apply during this coordination process.

B. **Coordination mechanisms:** The MCO/SE shall work proactively to achieve appropriate coordination between physical and behavioral health services by implementing complimentary policies and procedures for the coordination of services. The MCO/SE shall implement policies and procedures that maximize care coordination to access medicaid services external to the MCO's program, such as home and community-based waiver programs, the medicaid school-based services (MSBS) program and the children's medical services (CMS). The MCO/SE shall have procedures that ensure PCPs consistently receive communication, with the member's written consent, regarding member status and follow-up care by a specialist provider. The MCO/SE shall provide comprehensive education to its provider networks regarding HIPAA compliant protocols for sharing information between physical health, behavioral health and other providers.

C. **Referrals for behavioral health services:** The MCO shall educate and assist the PCPs regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment through the SE.

D. **Referrals for physical health services:** The SE shall educate and assist the behavioral health providers regarding proper procedures for making appropriate referrals for physical health consultation and treatment when accessing needed physical health services. The SE shall coordinate care with primary care providers, with the member's written consent.

E. **Referral policies and procedures:** The MCO/SE shall offer statewide trainings to all providers regarding its specific referral policies and procedures. The MCO/SE shall develop and implement policies and procedures that encourage PCPs to refer members to the SE for behavioral health services or directly to behavioral health service providers in an appropriate and timely manner, with the member's documented permission. These referral policies and procedures shall be provided in provider manuals distributed to all contracted providers. A member may access behavioral health services through direct contact with the SE or by going directly to a behavioral health provider. A written report of the behavioral health service containing sufficient information to coordinate the member's care shall be forwarded to the PCP by the behavioral health provider with the member's written consent with oversight from the SE within seven calendar days after screening and evaluation.

F. **Indicators for PCP referral to behavioral health services:** The following are common indicators for a referral to the SE for behavioral health services or for a referral directly to a behavioral health provider by a PCP:

(1) suicidal/homicidal ideation or behavior;

(2) at-risk of hospitalization due to a behavioral health condition;

(3) children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital, residential treatment facility, or treatment foster care placement;

(4) trauma victims including possible abused or neglected members;

(5) serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

(6) request by member, parent or legal guardian of a minor for behavioral health services;

(7) clinical status that suggests the need for behavioral health services;

(8) identified psychosocial stressors and precipitants;

(9) treatment compliance complicated by behavioral characteristics;

(10) behavioral, psychiatric or substance abuse factors influencing a medical condition;

(11) victims or perpetrators of abuse and neglect;

(12) non-medical management of substance abuse;

(13) follow-up to medical detoxification;

(14) an initial PCP contact or routine physical examination indicates a substance abuse or mental health problem;

(15) a prenatal visit indicates a substance abuse or mental health problem;

(16) positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;

(17) a pattern of inappropriate use of medical, surgical, trauma, urgent care or emergency room services that could be related to substance abuse or other behavioral health conditions; and

(18) the persistence of serious functional impairment.

G. **Referrals for physical health or behavioral health consultation and treatment:** The SE shall educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment to the medicaid member's PCP or MCO as authorized by the member. The MCO shall educate and assist the physical health providers to make appropriate referrals for behavioral health consultation and treatment.

H. **Independent access:** The MCO/SE shall develop and implement policies and procedures that allow members access to behavioral health services through the SE directly and without referral from the PCP. These policies and procedures shall require timely access to behavioral health services.

I. **Behavioral health plan:** The behavioral health provider designated as the "clinical home" shall take responsibility for developing and implementing the member's behavioral health treatment plan in coordination with the member, parent or legal guardian and other providers, when clinically indicated. With the member's documented permission, multiple behavioral health providers shall coordinate their treatment plans and progress information to provide optimum care for the member. Community case managers shall be responsible for monitoring the treatment plan and coordinating treatment team meetings for members receiving behavioral health care from multiple providers.

J. **On-going reporting:**

(1) The SE shall require that a behavioral health provider must keep the member's PCP informed, with the member's written consent, of the following:

(a) drug therapy;
(b) laboratory and radiology results;
(c) sentinel events such as hospitalization, emergencies, and incarceration;
(d) discharge from a psychiatric hospital, residential treatment services, treatment foster care placement or from other behavioral health services; and
(e) all transitions in level of care.

(2) The MCO shall require that a PCP must keep the member's behavioral health provider informed, with the member's written consent, of the following:

(a) drug therapy;
(b) laboratory and radiology results;
(c) medical consultations; and
(d) sentinel events such as hospitalization and emergencies.

K. **Psychiatric consultation:** The PCP and all behavioral health providers are encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from an SE contracted psychiatrist or other behavioral health specialist with prescribing authority, when clinically appropriate.
[8.305.9.10 NMAC - Rp 8.305.9.10 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.11 COORDINATION WITH WAIVER PROGRAMS: The MCO/SE shall have policies and procedures governing coordination of services with home and community-based medicaid waiver programs to assist with complex care coordination. The MCO/SE shall coordinate care with the member's waiver case manager or the mi via consultant to ensure that medical information is shared, following HIPAA guidelines, and that medically necessary services are provided and are not duplicated. HSD shall monitor utilization of services by waiver recipients to ensure that the MCO/SE provides to members who are waiver participants all benefits included in the medicaid benefit package.
[8.305.9.11 NMAC - Rp 8.305.9.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-09]

8.305.9.12 COORDINATION OF SERVICES WITH CHILDREN, YOUTH AND FAMILIES DEPARTMENT (CYFD) AND AGING AND LONG TERM SERVICES DEPARTMENT (ALTSD): The MCO/SE shall have policies and procedures governing coordination of services with the CYFD protective services division (PSD) and juvenile justice division (JJD). If the member is receiving case management services through CYFD, the primary responsibility for the case management function remains with CYFD, and the MCO/SE shall assist with care coordination. Care coordination shall ensure that members receive medically necessary services, including behavioral health services through the SE, regardless of the member's custody status. If child protective services (CPS) or juvenile justice division (JJD) has an open case on a member, the CYFD social worker assigned to the case shall be involved in the assessment and treatment plan, including decisions regarding the provision of services for the member. The MCO/SE shall have policies and procedures governing coordination of services with ALTSD's adult protective services. The MCO/SE shall ensure that any APS worker actively involved in an individual's life is included in care coordination. The MCO/SE shall assist CYFD and ALTSD staff in identifying access to all medically necessary services identified in the care coordination plan. The MCO/SE shall designate a single contact point within the MCO/SE for care coordination purposes.

A. **Children's Code compliance:** The MCO/SE policies and procedures shall comply with the current New Mexico Children's Code.

B. **Adult Protective Services Act compliance:** The MCO/ SE's policies and procedures shall comply with New Mexico Statutes, Chapter 27, Section 7 (27-7-14 through 27-7-31), the "Adult Protective Services Act."
[8.305.9.12 NMAC - Rp 8.305.9.12 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07]

8.305.9.13 COORDINATION OF SERVICES WITH SCHOOLS: The MCO/SE shall implement policies and procedures regarding coordination with the public schools for members receiving medicaid services excluded from managed care, as specified by an individual education plan (IEP) or individualized family service plan (IFSP). If the member receives case management through the IEP or IFSP, the primary responsibility for the case management function remains with the school, and the MCO/SE shall assist with care coordination. Coordination between the schools and the MCO/SE shall ensure that members receive medically necessary services that complement the IEP or IFSP services and promote the highest level of function for the child. The MCO/SE shall be responsible for implementing policies and procedures for coordination of services for children returning to school after extended absences, which may be due to inpatient, residential treatment services or treatment foster care placement.
[8.305.9.13 NMAC - Rp 8.305.9.13 NMAC, 7-1-04; A, 7-1-05]

HISTORY OF 8.305.9 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.8, Managed Care Policies, Coordination of Services, 6-19-97.

History of Repealed Material:
8 NMAC 4.MAD.606.8, Managed Care Policies, Coordination of Services - Repealed, 7-1-01.
8.305.9 NMAC, Medicaid Managed Care, Coordination of Services - Repealed 7-1-04.