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8.306.1 GENERAL PROVISIONS

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TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 1 GENERAL PROVISIONS

8.306.1.1 ISSUING AGENCY: Human Services Department
[8.306.1.1 NMAC - N, 7-1-05]

8.306.1.2 SCOPE: This rule applies to the general public.
[8.306.1.2 NMAC - N, 7-1-05]

8.306.1.3 STATUTORY AUTHORITY: New Mexico Statutes Annotated, 1978 (Chapter 27, Articles 1 and 2) authorize the state to administer the medicaid program. The State Coverage Insurance (SCI) program is authorized under a health insurance flexibility and accountability (HIFA) waiver under section 1115 of the Social Security Act for the parent population and a medicaid demonstration waiver under section 1115 for the childless adult population, both subject to special terms and conditions.
[8.306.1.3 NMAC - N, 7-1-05; A, 6-1-10]

8.306.1.4 DURATION: The SCI program is operated subject to continuation of the state's HIFA waiver and the medicaid demonstration waiver, and subject to availability of funds.
[8.306.1.4 NMAC - N, 7-1-05; A, 6-1-10]

8.306.1.5 EFFECTIVE DATE: July 1, 2005, unless a later date is cited at the end of a section.
[8.306.1.5 NMAC - N, 7-1-05]

8.306.1.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico state coverage insurance program.
[8.306.1.6 NMAC - N, 7-1-05]

8.306.1.7 DEFINITIONS: The state of New Mexico is committed to reducing the number of uninsured working New Mexico residents and improving the number of small employers offering health benefit plans by implementation of a basic health coverage health insurance benefit provided by contracted managed care organization with cost sharing by members, employers and the state and federal governments. This section contains the glossary for the New Mexico state coverage insurance policy. The following definitions apply to terms used in this chapter.

A. Definitions beginning with letter "A":

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

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

(3) **Appeal, member:** A request from a member or provider, on the member's behalf with the member's written permission, for review by the managed care organization (MCO) of an MCO action as defined above in Paragraph (2) of Subsection A of 8.306.1.7 NMAC.

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

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

B. Definitions beginning with letter "B":

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

(2) **Behavioral health:** Refers to mental health and substance abuse.

(3) **Behavioral health purchasing collaborative (the collaborative):** Refer to the interagency behavioral health purchasing collaborative pursuant to the passage of HB 271 effective May 19, 2004. The collaborative is made up of 17 publicly funded statutory member agencies including 15 direct service providers and funding agencies, including the human services department.

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

(5) **Benefit year:** The year beginning with the month of enrollment in an MCO and payment of designated premiums if applicable and continuing for a period up to 12 continuous months as long as enrollment requirements are met.

(6) **Broker:** A person, partnership, corporation or professional corporation appointed by a health insurer licensed to transact business in New Mexico to act as its representative in any given locality for the purpose of soliciting and writing any policy or contract insuring against loss or expense resulting from the sickness of the insured.

C. Definitions beginning with letter "C":

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

(2) **Care coordination:** An office-based administrative function to assist members "at risk" for adverse outcomes to help meet their needs by filling in gaps in current health care on an as needed basis. Care coordination is member-centered, family-focused when appropriate, culturally competent and strengths-based, and ensures that the medical and behavioral health needs of the SCI population are identified and 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, other program personnel, and family; facilitating access to services; actively managing transitions of care, such as a hospital discharge; training of caregivers; and ongoing reassessment and refinement of the care plan. Care coordination operates independently within the MCO and has separately defined functions with a dedicated care coordination staff but is structurally linked to the other MCO systems, such as quality assurance, member services, and grievances. Clinical decisions shall be based on the medically necessary covered services and not on fiscal or administrative considerations. The care coordinator coordinates services within the physical and behavioral health delivery system, as well as with other service providing systems. The care coordinator may interface and collaborate with the member's case manager, or refer the member to case management as necessary. If both physical and behavioral health conditions exist, the primary care coordination responsibility lies with the condition that is most acute.

(3) **Case management**: Case management consists of services which help beneficiaries gain access to needed physical health, behavioral health, social, educational, and other services. A person or team of people who provide outreach to customers, provide information to them about services, work with them to develop a service plan, assist in obtaining needed services, supports and entitlements and advocate on their behalf. General case management is designed to access, coordinate and monitor services.

(4) **Category:** A designation of the automated eligibility system. SCI has one designated category (062) and three income groupings that are assigned to an individual based on their income grouping. The assigned category is applicable for a period of 12 consecutive months regardless of changes in income or family status, subject to change by request from the recipient.

(5) **Childless adult population:** Non-pregnant, childless adults, ages 19 through 64 years, with household income below 200 percent of the federal poverty level, who do not otherwise qualify for medicaid or medicare.

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

(7) **Client:** An individual who has applied for and been determined eligible for SCI. A "client" may also be referred to as a "member," "customer," or "consumer", or "program participant".

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

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

(10) **Comprehensive community support services**: These services are goal-directed mental health rehabilitation services and support for children, adolescents, and adults necessary to assist individuals in achieving recovery and resiliency goals. These services assist in the development and coordination of a member's service plan and include therapeutic interventions which address barriers that impede the development of skills necessary for independent functioning in the community.

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

(12) **Coordination of long-term services (CoLTS):** A coordinated program of physical health and community-based supports and services implemented under the authority of concurrent section 1915(b) and section 1915(c) waivers. The CoLTS program includes individuals eligible for both medicare and medicaid, and persons eligible for medicaid long-term care services based on assessed need for nursing facility level of care. The CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities and medically-fragile waiver programs.

(13) **Cost-sharing:** Premiums and co-payments owed by the member based on income group category.

(14) **Cost-sharing maximum:** The cost sharing maximum is determined during the initial eligibility determination and recertification process. The cost sharing maximum amount established at the point of eligibility determination for the benefit year represents an amount equal to five percent of the program participant's countable household income.

(15) **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable are met.

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

D. Definitions beginning with letter "D":

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

(2) **Denial-administrative/technical:** A denial of authorization requests due to the requested procedure, service or item not being covered by SCI, not being on the MCO pharmacy drug list, or due to provider noncompliance with administrative policies and procedures established by either the SCI MCO or the medical assistance division.

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

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

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

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

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

E. Definitions beginning with letter "E":

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

(2) **Employer:** An employer with 50 or fewer eligible employees on a full or part time basis.

(3) **Employer group:** A group of employees employed by an eligible employer who receive SCI benefits through the employer or a self-employed person who will be considered a group of one.

(4) **Employee:** A person employed by an employer who participates in the SCI health benefit plan.

(5) **Encounter:** The record of a physical or behavioral health service rendered by a provider to an MCO member, client, customer or consumer.

(6) **Enrollee:** A SCI recipient who is currently enrolled in a managed care organization.

(7) **Enrollee rights:** Rights which each SCI enrollee is guaranteed.

(8) **Enrollment:** The process of enrolling eligible members in an MCO for purposes of management and coordination of health care delivery. The process of enrolling members either by the employer or individually in an available SCI-participating MCO for purposes of health care coverage. Enrollment encompasses selection of an MCO, notification of the selection to the MCO, and timely payment of premiums to the MCO as determined by the MCO.

(9) **Expedited appeal:** A federally mandated provision for an expedited resolution within 72 hours of the requested appeal, which includes an expedited review by the MCO of an MCO action.

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

F. Definitions beginning with letter "F":

(1) **Family planning services:** Services provided to members of childbearing age to temporarily or permanently prevent or delay pregnancy (see 8.325.3 NMAC [MAD-762], *Reproductive Health Services*).

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

(3) **Full risk contracts:** Contracts that place the MCO at risk for furnishing or arranging for comprehensive services.

G. Definitions beginning with letter "G":

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

(2) **Grievance (member):** Oral or written statement by a member expressing dissatisfaction with any aspect of the MCO or its operations that is not an MCO action.

(3) **Grievance (provider):** Oral or written statement by a provider to the MCO regarding utilization management decisions or provider payment issues.

(4) **Group of one:** Individuals who enroll without an employer group but report self-employment.

H. Definitions beginning with letter "H":

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

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

(3) **Hospitalist:** A physician employed by a hospital to manage the care of a member admitted to the hospital for inpatient care.

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

I. Definitions beginning with letter "I":

(1) **Income groupings:** 0-100 percent, 101-150 percent, and 151-200 percent of federal poverty levels: These income groupings define the premium, copayment, and cost-sharing maximums for SCI cost-sharing purposes.

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

(3) **Individual:** A person who enrolls in SCI who is not a member of an eligible employer group and pays the premium amount designated for both the employee and employer share, if applicable, based on household income, or has that amount paid on his behalf by another entity.

J. Definitions beginning with letter "J": [RESERVED]

K. Definitions beginning with letter "K": [RESERVED]

L. Definitions beginning with letter "L": [RESERVED]

M. Definitions beginning with letter "M":

(1) **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage, coordinate and receive payment for the delivery of specified services to enrolled members from a certain geographic area. Also referred to as a managed care plan and managed care program.

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

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

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

(5) **Medically necessary services:**

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

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

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

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

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

(b) Application of the definition:

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

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

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

(6) **Member:** A eligible member enrolled in an MCO.

(7) **Member month:** A calendar month during which a member is enrolled in an MCO.

(8) **Mi via home and community-based waiver**: The New Mexico self-directed medicaid waiver program that supports New Mexicans with disabilities and the elderly by allowing recipients to be active participants in choosing where and how they live and what services and supports they purchase.

N. Definitions beginning with letter "N":

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

(2) **Network provider:** An individual provider, clinic, group, association or facility employed by or contracted with an MCO to furnish physical or behavioral health services to the MCO's members under the provisions of the SCI managed care contract.

(3) **Notice:** A written statement that includes what action is being taken, the reasons for the intended action, the specific regulation that requires the action, and an explanation of the circumstances under which the service may be continued if a hearing is requested.

O. Definitions beginning with letter "O": **Outreach:** The act or process of promoting an insurance product through established business channels of communications including brochures, leaflets, internet, print media, electronic media, signage or other materials used by MCOs to attract or retain SCI enrollment primarily through employer groups.

P. Definitions beginning with letter "P":

(1) **Parent population:** Uninsured parents, ages 19 through 64, of medicaid and CHIP-eligible children, who are not otherwise eligible for medicaid or medicare, with household income below 200 percent of the federal poverty level.

(2) **Parental or custodial relative status:** The state of having a dependent child under the age of 18 who is the son, daughter, or relative within the fifth degree of relationship living in the household and under the care and control of the individual.

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

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

(5) **Performance measurement (PM):** Data specified by the state that enables the MCO's performance to be determined.

(6) **Plan of care:** A written document including all medically necessary services to be provided by the MCO for a specific member.

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

(8) **Potential enrollee:** A medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

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

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

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

(12) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

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

Q. Definitions beginning with letter "Q": [RESERVED]

R. Definitions beginning with letter "R":

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

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

(3) **Reduction of care:** A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service, based on the member's physical health, medical or behavioral health clinical need, than was originally requested, except pharmaceutical services which are covered by the formulary process.

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

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

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

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

S. Definitions beginning with letter "S":

(1) **Salud!:** the New Mexico managed care program implemented in 1997, covering children, pregnant women and disabled New Mexicans. Parents of medicaid-eligible children are also covered by medicaid if they meet eligibility requirements.

(2) **SCI (state coverage insurance):** The New Mexico health care program implemented under the authority of the health insurance flexibility and accountability (HIFA) waiver granted to the state by the centers for medicare and medicaid services (CMS).

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

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

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

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

T. Definitions beginning with letter "T":

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

(2) **Third party:** An individual entity or program, which is or may be, liable to pay all or part of the expenditures for SCI members for services furnished.

(3) **Transition of care:** Refers to the movement of patients from one health care practitioner or setting to another as their condition and care requires change.

U. Definitions beginning with letter "U": **Urgent condition:** Acute signs and symptoms, which, by reasonable medical judgment, represent a condition of sufficient severity such that the absence of medical attention within 24 hours could reasonably be expected to result in an emergency condition.

V. Definitions beginning with the letter "V": **Value added benefit:** Any benefit offered to members by the MCO that is not included in the SCI benefit package.

[8.306.1.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 6-1-08; A, 7-1-09; A, 6-1-10]

8.306.1.8 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 community.

[8.306.1.8 NMAC - N, 7-1-05; A, 7-1-09]

HISTORY OF 8.306.1 NMAC: [RESERVED]