

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 20 REIMBURSEMENT

8.308.20.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.20.1 NMAC - N, 1-1-14]

8.308.20.2 SCOPE: This rule applies to the general public.
[8.308.20.2 NMAC - N, 1-1-14]

8.308.20.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-1-12 et seq.
[8.308.20.3 NMAC - N, 1-1-14]

8.308.20.4 DURATION: Permanent.
[8.308.20.4 NMAC - N, 1-1-14]

8.308.20.5 EFFECTIVE DATE: January 1, 2014, unless a later date is cited at the end of a section.
[8.308.20.5 NMAC - N, 1-1-14]

8.308.20.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.20.6 NMAC - N, 1-1-14]

8.308.20.7 DEFINITIONS: [RESERVED]

8.308.20.8 ~~[MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico by providing support services that help families break the cycle of dependency on public assistance.]~~ [RESERVED]
[8.308.20.8 NMAC - N, 1-1-14; A, xx-xx-xx]

8.308.20.9 REIMBURSEMENT FOR MANAGED CARE:

A. Payment for services: HSD shall make actuarially sound payments, in accordance with 42 C.F.R. 438.6(c), for the provision of the managed care medicaid benefit package, under capitated risk contracts to the designated managed care organizations (MCOs). Rates whether set by HSD or negotiated between HSD and the MCO are confidential.

(1) At the sole discretion of HSD, rates shall be appropriate for the medicaid populations to be covered and the services to be furnished under the contract. Rates may be adjusted based on factors, including but not limited to, changes in the scope of work; CMS requiring a modification of the 1115(a) waiver; new or amended federal or state statutes, regulations or rules; inflation; significant changes in the demographic characteristics of the member population; or the disproportionate enrollment selection of the MCO by members in certain rate cohorts.

(2) The MCO shall be responsible for the provision of services for members during the month of capitation. A medicaid eligible recipient shall not be liable for debts or costs incurred by an MCO under the MCO's managed care contract for providing health care to him or her. This includes but is not limited to:

- (a) the MCO's debts in the event of its insolvency;
- (b) services provided to the member that are not included in the medicaid benefit package and for which HSD does not pay the MCO, e.g., value added services;
- (c) instances when the MCO does not pay the health care provider who furnishes the services under contractual, referral, or other arrangement;
- (d) payments for covered services furnished under contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly; and
- (e) if a MCO member loses eligibility for any reason and is reinstated as eligible by HSD before the end of the month, the MCO shall accept a retroactive capitation payment for that month of

eligibility and assume financial responsibility for all medically-necessary covered benefit services supplied to the member.

(3) Retroactive capitation payments may not be issued for a member for the same coverage month in which fee-for-service claims have already been paid by HSD except in special situations determined by HSD.

B. Capitation disbursement requirements: HSD shall pay a capitated amount to the MCO for the provision of the managed care benefit package at specified rates. The monthly rate is based on actuarially sound capitation rate cells. The MCO shall accept the capitation rate paid each month by HSD as payment in full for all services including all administrative costs associated therewith, including gross receipts tax payable to the provider. The MCO is at risk of incurring losses if the cost of providing the managed care medicaid benefit package exceeds its capitation payment. HSD shall not provide retroactive payment adjustments to the MCO to reflect the actual cost of services furnished by the MCO.

C. Capitation recoupments: HSD shall have the discretion to recoup capitations or payments as provided for in its contract with the MCO.

- (1) Instances when HSD shall recoup payments for members include, but are not limited to:
- (a) member incorrectly enrolled with more than one MCO;
 - (b) member who dies prior to the enrollment month for which payment was made;

or

(c) member who HSD later determines was not eligible for medicaid during the enrollment month, including retroactive months for which payment was made.

(2) HSD acknowledges and agrees that in the event of any recoupment pursuant to this rule, the MCO shall have the right to recoup from a provider or another person to whom the MCO has made payment during this period of time; however, may not recoup payments for any value added services provided. Recouped payments to a provider is subject to the time periods governed by the MCO provider agreement.

(3) Any duplicate payment identified by either the MCO or HSD shall be recouped upon identification.

(4) The MCO has the right to dispute any recoupment action in accordance with contractual provisions.

D. Patient liability: HSD monthly capitation payments will be net of patient liability. The capitation payments are developed on "gross" cost and will be reduced by the amount of average patient member responsibility each month. The MCO shall delegate the collection of patient member liability to the nursing facility or community-based residential alternative facility and shall pay the facility net of the applicable patient member liability amount. The MCO shall submit patient member liability information associated with claim payments in their encounter data submissions.

E. Payment time frames: A clean claim shall be paid by the MCO to contracted and non-contracted providers according to the following timeframe: a) 90 percent within 30 calendar days of the date of receipt and b) 99 percent within 90 calendar days of the date of receipt, as required by federal guidelines in the code of federal regulations Section 42 CFR 447.45. The date of receipt is the date the MCO first receives the claim either manually or electronically. The MCO is required to date stamp all claims on the date of receipt. The date of payment is the date of the check or other form of payment. An exception to this requirement may be made if the MCO and its providers by mutual agreement establish an alternative payment schedule. However, any such alternative payment schedule shall first be incorporated into the contract between HSD and the MCO. The MCO shall be financially responsible for paying all claims for all covered, emergency and post-stabilization services that are furnished by non-contracted providers, at no more than the medicaid fee-for-service rate, including medically or clinically necessary testing to determine if a physical or behavioral health emergency exists.

(1) The MCO shall pay a contracted and non-contracted provider interest on the MCO's liability at the rate of one and one-half percent per month on the amount of a clean claim (based upon the current medicaid fee schedule) submitted by the participating provider and not paid within 30 calendar days of the date of receipt of an electronic claim and 45 calendar days of receipt of a paper claim. Interest **shall be paid within 30 calendar days of claim adjudication, and** shall accrue from the 31st calendar day for electronic claims and from the 46th calendar day for manual claims. The MCO shall be required to report the number of claims and the amount of interest paid, on a timeframe determined by HSD/MAD.

(2) No contract between the MCO and a participating provider shall include a clause that has the effect of relieving either party of liability for its actions or inactions.

(3) If the MCO is unable to determine liability for or refuses to pay a claim of a participating provider within the times specified above, the MCO shall make a good-faith effort to notify the participating

provider by fax, electronically or via other written communication within 30 calendar days of receipt of the claim, stating specific reasons why it is not liable for the claim or request specific information necessary to determine liability for the claim.

F. Special payment requirements: This section lists special payment requirements by provider type.

(1) Reimbursement to a federally qualified health center (FQHC) and a rural health clinic (RHC): a contracted and non-contracted FQHC or RHC shall be reimbursed at a minimum of the prospective payment system (PPS) as determined by HSD or its designee or an alternative payment methodology in compliance with Section 1905(a)(2)(C) of the 1902 Social Security Act, as established by HSD.

(2) Reimbursement to Indian health service (IHS), tribal health providers, and urban Indian providers authorized to provide services as defined in the Indian Health Care Improvement Act, 25 U.S.C. 1601 et seq.

(a) The MCO shall reimburse IHS and tribal compact contracted and non-contracted provider as identified by HSD, at a minimum of 100 percent of the rate established for an IHS facility or federally-leased facility by the office of management and budget (OMB). For services designated by HSD to be paid at fee schedule rates rather than OMB rates, the MCO shall reimburse the IHS or tribal contract provider at not less than the MAD fee schedule rate.

(b) IHS facilities, tribal health providers and urban Indian providers shall have up to two years from a claim's first date of service to submit a claim; claims not submitted within two years of the first date of service are not eligible for reimbursement.

(c) With the exception of residential treatment center services, services provided by IHS or a tribal 638 facility is not subject to prior authorization.

(3) Reimbursement for family planning services: the MCOs shall reimburse an out-of-network family planning provider for services provided to a MCO member at a rate that is at least equal to the MAD fee-schedule rate for the provider type.

(4) Reimbursement for a woman in her second or third trimester of pregnancy: If a woman is in the second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to her enrollment in the MCO, the receiving MCO will be responsible for providing continued access to her prenatal care provider (whether a contracted or non-contracted provider) through the two month postpartum period without any form of prior approval.

5) Reimbursement for a MCO member who disenrolls transitions while hospitalized: If an eligible recipient is hospitalized at the time of enrollment into or disenrollment from managed care or upon an approved switch from one MCO to another, the relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, or a non-psychiatric specialty unit or hospitals as designated by the New Mexico department of health (DOH). The payer at the date of admission remains responsible for the services until the date of discharge. Upon discharge, the member will then become the financial responsibility of the receiving MCO receiving capitation payments. The relinquishing MCO shall be responsible for payment of all covered inpatient facility and professional services up to the date of disenrollment from the MCO.

[8.308.20.9 NMAC - N, 1-1-14; A, xx-xx-xx]

HISTORY OF 8.308.20 NMAC: [RESERVED]