TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 9 BENEFIT PACKAGE

8.308.9.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.9.1 NMAC - Rp, 8.308.9.1 NMAC, 5/1/2018]

8.308.9.2 SCOPE: This rule applies to the general public.
[8.308.9.2 NMAC - Rp, 8.308.9.2 NMAC, 5/1/2018]

8.308.9.3 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 Section 27-1-12 et seq., NMSA 1978.
[8.308.9.3 NMAC - Rp, 8.308.9.3 NMAC, 5/1/2018]

8.308.9.4 DURATION: Permanent.
[8.308.9.4 NMAC - Rp, 8.308.9.4 NMAC, 5/1/2018]

8.308.9.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.9.5 NMAC - Rp, 8.308.9.5 NMAC, 5/1/2018]

8.308.9.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance division programs.
[8.308.9.6 NMAC - Rp, 8.308.9.6 NMAC, 5/1/2018]

8.308.9.7 DEFINITIONS:

A. Alternative benefits plan services with limitations (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member under the age of 21 years are not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MCO ABP contracted provider and an ABP member have rights and responsibilities as described in Title 8 Chapter 308 NMAC, Social Services.

B. Alternative benefits plan general benefits for ABP exempt member (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by the MCO's utilization management for determination if he or she meets the qualifying condition. An ABP exempt member utilizes his or her benefits described in 8.308.9 NMAC and in 8.308.12 NMAC.
[8.308.9.7 NMAC - Rp, 8.308.9.7 NMAC, 5/1/2018]

8.308.9.8 [**RESERVED**]
[8.308.9.8 NMAC - Rp, 8.308.9.8 NMAC, 5/1/2018]

8.308.9.9 BENEFIT PACKAGE: This part defines the benefit package for which a MCO shall be paid a fixed per-member-per-month capitated payment rate. The MCO shall cover the services specified in 8.308.9 NMAC. The MCO shall not delete a benefit from the MCO benefit package. A MCO is encouraged to offer value added services that are not medicaid covered benefits or in lieu of services or settings. The MCO may utilize providers licensed in accordance with state and federal requirements to deliver services. The MCO shall provide and coordinate comprehensive and integrated health care benefits to each member enrolled in managed care and shall cover the physical health, behavioral health and long-term care services per this section, its contract, and as directed by HSD. If the MCO is unable to provide covered services to a particular member using one of its contracted providers, the MCO shall adequately and timely cover these services for that member using a non-contract provider for as long as the member's MCO provider network is unable to provide the service. At such time

that the required services become available within the MCO's network and the member can be safely transferred, the MCO may transfer the member to an appropriate contract provider according to a transition of care plan developed specifically for the member; see 8.308.11 NMAC.
[8.308.9.9 NMAC - Rp, 8.308.9.9 NMAC, 5/1/2018]

8.308.9.10 MEDICAL ASSISTANCE DIVISION PROGRAM RULES: New Mexico administrative code (NMAC) rules and related documents contain a detailed description of the services covered by MAD, the limitations and exclusions to covered services, and non-covered services. The NMAC rules are the official source of information on covered and non-covered services. Unless otherwise directed, the MCO shall determine its own utilization management (UM) protocols and shall comply with state and federal requirements for UM including, but not limited to 42 CFR Part 456, which is based on reasonable medical evidence. The MCO shall comply with the most rigorous standards or applicable provisions of either NCQA, HSD regulation, the Balanced Budget Act of 1997, or 42 CFR Part 438 related to timeliness of decisions. The MCO shall ensure that medicaid covered benefits are furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries pursuant to 42 CFR 440.230. MAD may review and approve the MCO's UM protocols. Unless otherwise directed by MAD, a HSD contracted MCO is not required to follow MAD's reimbursement methodologies or MAD's fee schedules unless otherwise required in a NMAC rule. The MCO shall comply with 42 CFR Parts 438, 440, and 456.
[8.308.9.10 NMAC - Rp, 8.308.9.10 NMAC, 5/1/2018]

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit; benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by a qualified professional who has personally evaluated the member within his or her scope of practice; who has taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or his or her authorized representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems;

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis; medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a covered benefit.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or his or her authorized representative shall have the right to seek a second opinion from a qualified health care professional within his or her MCO's network,

or the MCO 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 his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in 8.308.10 NMAC, Care Coordination.

E. The MCO shall meet all behavioral health parity requirements as set forth in CFR 42, Chapter IV, subchapter C, 438.905 - Parity requirements.

[8.308.9.11 NMAC - Rp, 8.308.9.11 NMAC, 5/1/2018]

8.308.9.12 GENERAL COVERED SERVICES:

A. Ambulatory surgical services: The benefit package includes surgical services rendered in an ambulatory surgical center setting as detailed in 8.324.10 NMAC.

B. Anesthesia services: The benefit package includes anesthesia and monitoring services necessary for the performance of surgical or diagnostic procedures as detailed 8.310.2 NMAC.

C. Audiology services: The benefit package includes audiology services as detailed in 8.310.2 and 8.324.5 NMAC with some limitations. For a ABP member 21 years and older, audiology services are limited to hearing testing or screening when part of a routine health exam and are not covered as a separate service. Audiologist services, hearing aids and other aids are not covered.

D. Client transportation: The benefit package covers expenses for transportation, meals, and lodging it determines are necessary to secure MAD covered medical or behavioral health examination and treatment for a MCO member in or out of his or her home community as detailed in 8.301.6, 8.324.7 and 8.310.2 NMAC.

E. Community intervener: The benefit package includes community intervener services. The community intervener works one-on-one with a deaf-blind member who is five-years of age or older to provide critical connections to other people and his or her environment. The community intervener opens channels of communication between the member and others, provides access to information, and facilitates the development and maintenance of self-directed independent living.

(1) Member eligibility: To be eligible for community intervener services, a member must be five-years of age or older and meet the clinical definition of deaf-blindness, defined as:

(a) the member has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(b) the member has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or the progressive hearing loss having a prognosis leading to this condition; and

(c) the member for whom the combination of impairments described above cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(2) Provider qualifications: The minimum provider qualifications for a community intervener are as follows:

(a) is at least 18 years of age;

(b) is not the spouse of the member to whom the intervener is assigned;

(c) holds a high school diploma or a high school equivalency certificate;

(d) has a minimum of two years of experience working with individuals with developmental disabilities;

(e) has the ability to proficiently communicate in the functional language of the deaf-blind member to whom the intervener is assigned; and

(f) completes an orientation or training course by any person or agency who provides direct care services to deaf-blind individuals.

F. Dental services: The benefit package includes dental services as detailed in 8.310.2 NMAC.

G. Diagnostic imaging and therapeutic radiology services: The benefit package includes medically necessary diagnostic imaging and radiology services as detailed in 8.310.2 NMAC.

H. Dialysis services: The benefit package includes medically necessary dialysis services as detailed in 8.310.2 NMAC. Dialysis benefits are limited to the first three months of dialysis pending the establishment of medicare eligibility unless the member does not qualify for medicare benefits as determined by the social security administration. A dialysis provider shall assist a member in applying for and pursuing final medicare eligibility

determination. If the member does not qualify for medicare benefits, the MCO is responsible for covering dialysis services.

I. Durable medical equipment and medical supplies: The benefit package includes covered vision appliances, hearing aids and related services and durable medical equipment and medical supplies and oxygen as detailed in 8.324.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

J. Emergency and non-emergency transportation services:

(1) The benefit package includes transportation service such as ground ambulance and air ambulance in an emergency and when medically necessary, and taxicab and handivan, commercial bus, commercial air, meal and lodging services as indicated for medically necessary physical and behavioral health services, as detailed in 8.324.7 NMAC. MAD covers the most appropriate and least costly transportation alternatives only when a member does not have a source of transportation available and the member does not have access to alternative free sources. The MCO shall coordinate efforts when providing transportation services for a member requiring physical or behavioral health services.

(2) The benefit package also includes non-medical transportation as detailed in 8.314.5 NMAC.

K. Experimental or investigational services: The benefit package includes medically necessary services which are not considered unproven, investigational or experimental for the condition for which they are intended or used as determined by MAD as detailed in 8.310.2 NMAC.

L. Health home services: The benefit package includes CareLink NM (or its successor) health home services as detailed in 8.310.10 NMAC for qualified beneficiaries in areas these services are available through by MAD-approved providers.

M. Home health agency services and other nursing care: The benefit package includes home health agency services as detailed in 8.325.9 and 8.320.2 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

(1) A MCO may also cover private duty nursing services and in home rehabilitation services as needed to provide medically necessary services to members even though those services are not rendered through a home health agency.

(2) In addition to home health agency services, a MCO is also required to provide in home services under the EPSDT program through private duty nursing and EPSDT personal care (which is not to be confused with the personal care option services covered as a community benefit). See 8.308.9.15 NMAC regarding EPSDT services.

(3) Services in the home are also a benefit under community based services. See 8.308.12. NMAC Community Benefit.

(4) For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations.

N. Hospice services: The benefit package includes hospice services as detailed in 8.325.4 NMAC.

O. Hospital outpatient service: The benefit package includes hospital outpatient services for preventive, diagnostic, therapeutic, rehabilitative or palliative medical or behavioral health services as detailed in 8.311.2 NMAC.

P. Inpatient hospital services: The benefit package includes hospital inpatient acute care, procedures and services for the member as detailed in 8.311.2 NMAC. The MCO shall comply with the maternity length of stay in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Coverage for a hospital stay following a normal, vaginal delivery may not be limited to less than 48 hours for both the member and her newborn child. Health coverage for a hospital stay in connection with childbirth following a caesarean section may not be limited to less than 96 hours for the member and her newborn child.

Q. Laboratory services: The benefit package includes laboratory services provided according to the applicable provisions of Clinical Laboratory Improvement Act (CLIA) as detailed in 8.310.2 NMAC.

R. Nursing facility services: The benefit package includes nursing facility services as detailed in 8.312.2 NMAC. Nursing facility services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

S. Nutrition services: The benefit package includes nutritional services based on scientifically validated nutritional principles and interventions which are generally accepted by the medical community and consistent with the physical and medical condition of the member as detailed in 8.310.2 NMAC.

T. Physical health services:

(1) Primary care and specialty care services are found in the following 8.310.2, 8.310.3, 8.320.2, and 8.320.6 NMAC. The services are rendered in a hospital, clinic, center, office, school-based setting, and when facilities and settings are parent approved, including the home.

(2) The benefits specifically include:

(a) labor and delivery in a hospital;

(b) labor and delivery in an eligible recipient's home;

(c) labor and delivery in a midwife's unlicensed birth center;

(d) labor and delivery in a department of health licensed birth center; and

(e) other related birthing services performed by a certified nurse midwife or a direct-entry midwife licensed by the state of New Mexico, who is either validly contracted with and fully credentialed by the MCO or validly contracted with HSD and participates in MAD birthing options program as detailed in 8.310.2 NMAC.

(f) 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.

(g) The MCO shall participate in MAD's birthing options program.

U. Podiatry: The benefit package includes podiatric services furnished by a provider, as required by the condition of the member as detailed in 8.310.2 NMAC.

V. Prosthetics and orthotics: The benefit package includes prosthetic and orthotic services as detailed in 8.324.5 NMAC.

W. Rehabilitation services: The benefit package includes inpatient and outpatient hospital, and outpatient physical, occupational and speech therapy services as detailed in 8.323.5 NMAC. For an ABP eligible recipient 21 years of age and older, see 8.309.4 NMAC for service limitations

X. Private duty nursing: The benefit package includes private duty nursing services for a member under 21 years of age. See Subsection M of 8.308.9.12 NMAC.

Y. Swing bed hospital services: This benefit package includes services provided in hospital swing beds to a member expected to reside in such a facility on a long-term or permanent basis as defined in 8.311.5 NMAC. Swing bed hospital services are not a benefit for an ABP eligible recipient except as a short term "step-down" hospital discharge prior to going home.

Z. Tobacco cessation services: The benefit package includes cessation services as described in 8.310.2 NMAC and education.

AA. Transplant services: The following transplants are covered in the benefit package as long as the procedures are not considered experimental or investigational: heart transplants, lung transplants, heart-lung transplants, liver transplants, kidney transplants, autologous bone marrow transplants, allogeneic bone marrow transplants and corneal transplants as detailed in 8.310.2 NMAC. See 8.325.6 NMAC for guidance whether MAD has determined if a transplant is experimental or investigational.

BB. Vision and eye care services: The benefit package includes specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases for a member as detailed in 8.310.2 NMAC. All services must be furnished within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and rules. For an ABP eligible recipient 21 years and older, the service limitations are listed below:

(1) Routine vision care is not covered.

(2) MAD does not cover refraction or eyeglasses other than for aphakia following removal of the lens.

CC. Other services: When an additional benefit service is approved by MAD, the MCO shall cover that service as well**.**

[8.308.9.12 NMAC - Rp, 8.308.9.12 NMAC, 5/1/2018]

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS: The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. Case management services for adults with developmental disabilities: Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. Case management services for pregnant women and their infants: Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. Case management services for traumatically brain injured adults: Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. Case management services for children up to the age of three: Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. Case management services for the medically at risk (EPSDT): Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

[8.308.9.13 NMAC - Rp, 8.308.9.13 NMAC, 5/1/2018]

8.308.9.14 PHARMACY SERVICES: The benefit package includes pharmacy and related services, as detailed in 8.324.4 NMAC.

A. The MCO may determine its formula for estimating acquisition cost and establishing pharmacy reimbursement.

B. The MCO shall include on the MCO's formulary or PDL all multi-source generic drug items with the exception of items used for cosmetic purposes, items consisting of more than one therapeutic ingredient, anti-obesity items, items that are not medically necessary and as otherwise approved by MAD. Cough, cold and allergy medications must be covered but all multi-source generic products do not need to be covered. This requirement does not preclude a MCO from requiring authorization prior to dispensing a multi-source generic item.

C. The MCO is not required to cover all multi-source generic over-the-counter items. Coverage of over-the-counter items may be restricted to instances for which a practitioner has written a prescription, and for which the item is an economical or preferred therapeutic alternative to the prescribed item.

D. The MCO shall cover brand name drugs and drug items not generally on the MCO formulary or PDL when determined to be medically necessary by the MCO or as determined by the MCO member appeal process or a HSD administrative hearing. See 8.308.15 NMAC.

E. Unless otherwise approved by MAD, the MCO shall have an open formulary for all psychotropic medications. Minor tranquilizers, sedatives, and hypnotics are not considered psychotropic medications for the purpose of this rule.

F. MCO shall ensure that a native American member accessing the pharmacy benefit at an Indian health service (IHS), tribal, and urban Indian (I/T/U) facility is exempt from the MCO's PDL when these pharmacies have their own PDL.

G. The MCO shall reimburse family planning clinics, school-based health centers (SBHCs) and the department of health (DOH) public health clinics for oral contraceptive agents and plan B when dispensed to a member and billed using healthcare common procedure coding (HCPC) codes and CMS 1500 forms.

H. The MCO shall meet all federal and state requirements related to pharmacy rebates and submit all necessary information as directed by HSD.

I. For a member 21 years of age and older not residing in an institution, the MCO must, at a minimum , cover the over-the-counter items which are insulin**,** diabetic test strips, prenatal vitamins, electrolyte replacement items, ophthalmic lubricants, pediculosides and scabicides, certain insect repellants, sodium chloride for inhalations, topical and vaginal antifungals and topical anti-inflammatories. Other over-the-counter items may be designated as covered items after making a specific determination that it is overall more economical to cover an over-the-counter item as an alternative to prescription items or when an over-the-counter item is a preferred therapeutic alternative to prescription drug items. Such coverage is subject to the generic-first coverage provisions. Otherwise, the eligible recipient 21 years and older, or his or her authorized representative is responsible for purchasing or otherwise obtaining an over-the-counter item.

(1) The MCO may cover additional over-the counter items, with or without prior authorization, at its discretion or as medically necessary when a specific regimen of over-the-counter drugs is required to treat chronic disease conditions.

(2) For a member under 21 years of age, the MCO must cover over-the-counter drug items as medically necessary for the member, with or without prior authorization.

J. The MCO shall meet all federal and state requirements for identifying drug items purchased under the 340B drug purchasing provisions codified as Section 340B of the federal Public Health Service Act.

[8.308.9.14 NMAC - Rp, 8.308.9.14 NMAC, 5/1/2018]

8.308.9.15 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Part 441, Subpart B) provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in 8.308.9.19 NMAC.

A. EPSDT nutritional counseling and services: The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. EPSDT personal care: The benefit package includes personal care services for a member.

C. EPSDT private duty nursing: The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. EPSDT rehabilitation services: A member under 21 years of age who is eligible for home and community based waiver services receives medically necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. Services provided in schools: The benefit package includes services to a member provided in a school, excluding those specified in his or her individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. Tot-to-teen health checks:

(1) The MCO shall adhere to the MAD periodicity schedule and ensure that each eligible member receives age-appropriate EPSDT screens (tot-to-teen health checks), referrals, and appropriate services and follow-up care. See 8.320.2 NMAC for detailed description of the benefits. The services include, but are not limited to:

(a) education of and outreach to a member or the member's family regarding the importance of regular screens and health checks;

(b) development of a proactive approach to ensure that the member receives the services;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(e) processes to document, measure and assure compliance with MAD's periodicity schedule; and

(f) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for developmental delay, vision and hearing screening, dental examinations and immunizations.

(2) The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

[8.308.9.15 NMAC - Rp, 8.308.9.15 NMAC, 5/1/2018]

8.308.9.16 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices including plan B and long acting reversible contraception.

B. The MCO shall provide a member with sufficient information to allow him or her to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. Pregnancy termination procedures: The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC.

[8.308.9.16 NMAC - Rp, 8.308.9.16 NMAC, 5/1/2018]

8.308.9.17 PREVENTIVE PHYSICAL 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 its practitioners and members. 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 conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of obtaining basic health and demographic information about the member, assisting the MCO in determining the need for a comprehensive needs assessment (CNA) for care coordination level assignment.

B. Family planning: The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is 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.

C. Guidance: The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's 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 a menopausal member 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 an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

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

E. Nurse advice line: The MCO shall provide a toll-free clinical telephone nurse advice 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) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

F. 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 a member 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 a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of a member who has 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.

G. 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, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer*: A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement*: A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer*: A female member 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 when 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.

(4) *Screening for chlamydia*: All sexually active female members 25 years of age and younger shall be screened for chlamydia. All female members over 25 years of age 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.

(5) *Screening for colorectal cancer*: A member 50 years of age and older, who is 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.

(6) *EPSDT screening for elevated blood lead levels*: A risk assessment for elevated blood lead levels shall be performed beginning at six months and repeated at nine months of age. A member shall receive a blood lead measurement at 12 months and 24 months of age. A member between the ages of three and six years, for whom no previous test exists, should also be tested, and screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(7) *EPSDT newborn screening*: A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen and any screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(8) *Screening for obesity*: A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, Rh (D) 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.

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

(11) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, Latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement*: A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks*: The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height, gender appropriate weight, and body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes*: A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>twenty percent over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (e.g. hispanic, native American, African American, Asian-Pacific islander);

(c) 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); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

(17) Screens and preventative screens shall be updated as recommended by the United States preventative services task force.

[8.308.9.17 NMAC - Rp, 8.308.9.17 NMAC, 5/1/2018]

8.308.9.18 TELEMEDICINE SERVICES: The benefit package includes telemedicine services as detailed in 8.310.2 NMAC.

A. The MCO must:

(1) promote and employ broad-based utilization of statewide access to Health Insurance Portability and Accountability Act (HIPAA)-compliant telemedicine service systems including, but not limited to, access to text telephones or teletype (TTYs) and 711 telecommunication relay services;

(2) follow state guidelines for telemedicine equipment or connectivity;

(3) follow accepted HIPAA and 42 CFR part two regulations that affect telemedicine transmission, including but not limited to staff and contract provider training, room setup, security of transmission lines, etc; the MCO shall have and implement policies and procedures that follow all federal and state security and procedure guidelines;

(4) identify, develop, and implement training for accepted telemedicine practices;

(5) participate in the needs assessment of the organizational, developmental, and programmatic requirements of telemedicine programs;

(6) report to HSD on the telemedicine outcomes of telemedicine projects and submit the telemedicine report; and

(7) ensure that telemedicine services meet the following shared values, which are ensuring: competent care with regard to culture and language needs; work sites are distributed across the state, including native American sites for both clinical and educational purposes; and coordination of telemedicine and technical functions at either end of network connection.

B. The MCO shall participate in project extension for community healthcare outcomes (ECHO), in accordance with state prescribed requirements and standards, and shall:

(1) work collaboratively with HSD, the university of New Mexico, and providers on project ECHO;

(2) identify high needs, high cost members who may benefit from project ECHO participation;

(3) identify its PCPs who serve high needs, high cost members to participate in project ECHO;

(4) assist project ECHO with engaging its MCO PCPs in project ECHO's center for medicare and medicaid innovation (CMMI) grant project;

(5) reimburse primary care clinics for participating in the project ECHO model;

(6) reimburse "intensivist" teams;

(7) provide claims data to HSD to support the evaluation of project ECHO;

(8) appoint a centralized liaison to obtain prior authorization approvals related to project ECHO; and

(9) track quality of care and outcome measures related to project ECHO.

[8.308.9.18 NMAC - Rp, 8.308.9.18 NMAC, 5/1/2018]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:

A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) Applied behavior analysis: The benefit package includes applied behavior analysis (ABA) services for a member 12 months of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member 12 months to three years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.

(2) Assertive community treatment services (ACT): The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) Behavioral health respite: Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines-respite services-for a detailed description. Behavioral health respite is not a benefit for ABP eligible recipients.

(4) Comprehensive community support services: The benefit package includes comprehensive community support services for a member.

(5) Crisis Services: The benefit package includes three types of crisis services:

(a) 24-hour crisis telephone support; and

(b) mobile crisis team; and

(c) crisis triage centers.

(6) Family support services: The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -family support services- for a detailed description. Family support services are not a benefit for ABP eligible recipients.

(7) Hospital outpatient services: The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(8) Inpatient hospital services: The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC.

(9) Intensive outpatient (IOP) services: The benefit package includes intensive outpatient services for a member 13 years of age.

(10) Medication assisted treatment (MAT) and Opioid Treatment Programs: The benefit package includes opioid treatment services for opioid addiction to a member through an opioid treatment center as

defined in 42 CFR Part 8, Certification of Opioid Treatment; and buprenorphine and related pharmaceuticals. Medication assisted treatments include use of buprenorphine and similarly acting products.

(11) Outpatient therapy services: The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(12) Psychological rehabilitation services: The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(13) Recovery services: The MCO benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -recovery services-for a detailed description. Recovery services are not a benefit for ABP eligible recipients.

B. Behavioral health EPSDT services: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Section 441.57) provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) Accredited residential treatment center (ARTC): The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) Behavior management skills development services (BMS): The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) Day treatment services: The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) Inpatient hospitalization services provided in freestanding psychiatric hospitals: The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) Multi-systemic therapy (MST): The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(6) Psychosocial rehabilitation services (PSR): The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(7) Treatment foster care I (TFC I): The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(8) Treatment foster care II (TFC II): The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(9) Residential non-accredited treatment center (RTC) and group home: The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The

need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.
[8.308.9.19 NMAC - Rp, 8.308.9.19 NMAC, 5/1/2018]

8.308.9.20 COMMUNITY BENEFIT SERVICES: The MCO shall cover community benefit services for a member who meets the specific eligibility requirements for each MCO community benefit service as detailed in 8.308.12 NMAC. When an additional community benefit service is approved by MAD, the MCO shall cover that service as well.
[8.308.9.20 NMAC - Rp, 8.308.9.20 NMAC, 5/1/2018]

8.308.9.21 ALTERNATIVE BENEFITS PLAN (ABP) BENEFITS FOR ABP MCO MEMBERS: The MAD category of eligibility "other adults" has an alternative benefit plan (ABP). The MCO shall cover the ABP specific services for an ABP member. Services are made available through a MCO under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member:

A. has limitations on specific benefits;

B. does not have all standard medicaid state plan benefits available; and

C. has some benefits, primarily preventive services that are available only to an ABP member. The ABP benefits and services are detailed in Sections 12 through 18 of 8.309.4 NMAC. All EPSDT services are available to an ABP member under 21 years. Services for an ABP member under the age of 21 years not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

(1) provider networks found in 8.308.2 NMAC;

(2) managed care eligibility found in 8.308.6 NMAC;

(3) enrollment and disenrollment from managed care found in 8.308.7 NMAC;

(4) managed care member education - rights and responsibilities found in 8.308.8 NMAC;

(5) care coordination found in 8.308.10 NMAC;

(6) transition of care found in 8.308.11 NMAC;

(7) managed care cost sharing found in 8.308.14 NMAC;

(8) managed care grievance and appeals found in 8.308.15 NMAC;

(9) managed care reimbursement found in 8.308.20 NMAC;

(10) quality management found in 8.308.21 NMAC; and

(11) managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.21 NMAC - Rp, 8.308.9.21 NMAC, 5/1/2018]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt): An ABP member who self-declares he or she has a qualifying condition is evaluated by his or her MCO for determination if he or she meets an ABP qualifying condition. An ABP exempt member may select to no longer utilize his or her ABP benefits package. Instead, the ABP exempt member will utilize his or her MCO's medicaid benefits package. See 8.308.9.11-20 NMAC for detailed description of the MCO medicaid benefit services. All services, services limitations and co-payments that apply to full benefit medicaid recipients apply to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that only apply to ABP recipients. The ABP co-payments do not apply to an ABP-exempt recipient. The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;

B. managed care eligibility found in 8.308.6 NMAC;

C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;

D. managed care member education - rights and responsibilities found in 8.308.8 NMAC;

E. care coordination found in 8.308.10 NMAC;

F. transition of care found in 8.308.11 NMAC;

G. community benefits found in 8.308.12 NMAC;

H. managed care member rewards found in 8.308.13 NMAC

I. managed care cost sharing found in 8.308.14 NMAC;

J. managed care grievance and appeals found in 8.308.15 NMAC;

K. managed care reimbursement found in 8.308.20 NMAC;

L. quality management found in 8.308.21 NMAC; and

M. managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.22 NMAC - Rp, 8.308.9.22 NMAC, 5/1/2018]

8.308.9.23 SERVICES EXCLUDED FROM THE MCO BENEFIT PACKAGE: MAD does not cover some services. For the following services that are covered in another MAP category of eligibility, reimbursement shall be made by MAD or its contractor. However, the MCO is expected to coordinate these services, when applicable, and ensure continuity of care by overseeing PCP consultations, medical record updates and general coordination.

A. Medicaid in the schools: Services are covered under 8.320.6 NMAC. Reimbursement for services is made by MAD or its contractor.

B. Special rehabilitation services-family infant toddler (FIT): Early intervention services provided for a member birth to three years of age who has or is at risk for a developmental delay. Reimbursement for services is made by MAD or its contractor.

[8.308.9.23 NMAC - Rp, 8.308.9.23 NMAC, 5/1/2018]

8.308.9.24 Emergency and post stabilization services.

A. In this section, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:

(1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

B. In this section, emergency services means covered inpatient and outpatient services as follows.

(1) Furnished by a provider that is qualified to furnish these services under the federal rules. See 42 CFR 438.114.

(2) Needed to evaluate or stabilize an emergency medical condition.

C. Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described 42 CFR 438.114 (e), to improve or resolve the member's condition.

D. The MCO is responsible for coverage and payment of emergency services and post-stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO may not deny payment for treatment obtained under either of the following circumstances.

(1) A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in Subsection A of 8.308.9.24 NMAC.

(2) A representative of the MCO instructs the member to seek emergency services.

E. The MCO may not:

(1) limit what constitutes an emergency medical condition with reference to Subsection A of 8.308.9.24 NMAC on the basis of lists of diagnoses or symptoms; or

(2) refuse to cover emergency services based on the emergency room provider or hospital not notifying the member's PCP or the MCO.

F. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

G. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO that is responsible for coverage and payment.

[8.308.9.24 NMAC - Rp, 8.308.9.24 NMAC, 5/1/2018]

8.308.9.25 Additional coverage requirements:

A. The MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

B. The services supporting members with ongoing or chronic conditions or who require long-term services and supports must be authorized in a manner that reflects the member's ongoing need for such services and supports.

C. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR 441.20, family planning services.

D. The MCO must specify what constitutes "medically necessary services" in a manner that:

(1) is no more restrictive than that used in the New Mexico administrative code (NMAC) MAD rules, including quantitative and non-quantitative treatment limits, as indicated in state statutes and rules. The state plan, and other state policy and procedures; and

(2) addresses the extent to which the MCO is responsible for covering services that address:

(a) the prevention, diagnosis, and treatment of a member's disease, condition, or disorder that results in health impairments or disability;

(b) the ability for a member to achieve age-appropriate growth and development;

(c) the ability for a member to attain, maintain, or regain functional capacity; and

(d) The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of his or her choice.

E. Authorization of services: For the processing of requests for initial and continuing authorizations of services, the MCO must:

(1) have in place, and follow, written policies and procedures;

(2) have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

(3) consult with the requesting provider for medical services when appropriate;

(4) authorize long term services and supports (LTSS) based on an enrollee's current needs assessment and consistent with the person-centered service plan;

(5) assure 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 an individual who has appropriate expertise in addressing the member's medical, behavioral health, or LTSS needs;

(6) notify the requesting provider, and give the member written notice of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested and the notice must meet the requirements of 42 CFR 438.404, timely and adequate notice of adverse benefit determination; and

(7) for drug items that require prior authorization and drug items that are not on the MCO preferred drug list:

(a) provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization;

(b) provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation;

(c) consider in the review process any medically accepted indications for the drug item consistent with the American hospital formulary service drug information; United States pharmacopeia-drug information (or its successor publications); the DRUGDEX information system; and peer-reviewed medical literature as described in section 1927(d)(5)(A) of the Social Security Act.

[8.308.9.25 NMAC - Rp, 8.308.9.25 NMAC, 5/1/2018]

HISTORY OF 8.308.9 NMAC: [**RESERVED**]

History of Repealed Material:

8.308.9 NMAC - Managed Care Program, Benefit Package, filed 12/17/2013 Repealed effective 5/1/2018.