State of New Mexico
Human Services Department
Human Services Register

I. DEPARTMENT
NEW MEXICO HUMAN SERVICES DEPARTMENT

II. SUBJECT
STATE COVERAGE INSURANCE (SCI)

III. PROGRAM AFFECTED
(TITLE XXI) MEDICAID

IV. ACTION
PROPOSED REGULATIONS

V. BACKGROUND SUMMARY
The Medical Assistance Division is proposing amendments to the State Coverage Insurance (SCI) rules to incorporate relevant updates related to the Managed Care regulation updates to be effective July 1, 2009, to reflect additional program requirements, and to effect various other minor revisions to clarify regulatory language.

VI. REGULATIONS
These proposed regulation changes refer to 8.262.400 NMAC, 8.262.500 NMAC, 8.262.600 NMAC, 8.306.1 NMAC, 8.306.2 NMAC, 8.306.3 NMAC, 8.306.4 NMAC, 8.306.5 NMAC, 8.306.6 NMAC, 8.306.7 NMAC, 8.306.8 NMAC, 8.306.11 NMAC, 8.306.12 NMAC, 8.306.13 NMAC, 8.306.15 NMAC, 8.306.16 NMAC and 8.352.2 NMAC of the Medical Assistance Program Manual. This register and the proposed changes are available on the Medical Assistance Division web site at http://www.hsd.state.nm.us/mad/registers/. If you do not have Internet access, a copy of the regulations may be requested by contacting the Medical Assistance Division at 827-3156.

VII. EFFECTIVE DATE
The Department proposes to implement these regulations effective July 1, 2009.

VIII. PUBLIC HEARING
A public hearing to receive testimony on these proposed regulations will be held at 10:30 AM on May 12, 2009, in the Rio Grande Room of the Toney Anaya Building, 2550 Cerrillos Road in Santa Fe.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in the public hearing, please contact the Division toll free at 1-888-997-2583 and ask for extension 7-3156. In Santa Fe call 827-3156. The Department's TDD system may be accessed toll-free at 1-800-659-8331 or in Santa Fe by calling 827-3184. The Department requests at least ten (10) days advance notice to provide requested alternative formats and special accommodations.

IX. ADDRESS

Interested persons may address written or recorded comments to:

Pamela S. Hyde, J.D., Secretary
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

These comments must be received no later than 5:00 PM on May 12, 2009. Written and recorded comments will be given the same consideration as oral comments made at the public hearing. Interested persons my also address comments via electronic mail to: Magdalena.Romero@state.nm.us.

X. PUBLICATIONS

Publication of these regulations approved by:

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PAMELA S. HYDE, J.D., SECRETARY
HUMAN SERVICES DEPARTMENT

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 400 RECIPIENT POLICIES

8.262.400.7 DEFINITIONS:

A. **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 a failure to provide a service in a timely manner. An untimely service authorization constitutes a denial and is thus considered an action.

B. **Authorized representative:** An individual or entity for whom or for which the applicant has signed a release of confidentiality and to whom notices will be sent.

C. **Benefits:** SCI-covered services provided by the SCI-participating MCO and for which payment is included in the capitation rate, as defined in 8.262.600 NMAC.

D. **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 in units of "per member per month" (PMPM).

E. **Catastrophic coverage:** Insurance coverage for specific catastrophic events, such as death, fire, flood, and some medical conditions.

F. **Category:** A designation of the automated eligibility system. 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.

G. **Cost-sharing:** Premiums and copayments owed by the member based on income group category.

H. **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 5[~~%~~] percent of the program participant's countable income.

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

J. **Eligibility:** The process of establishing that SCI residency, citizenship or alien status, health insurance coverage, income, living arrangement, and age requirements are met, as defined in this part and 8.262.500 NMAC.

K. **Employer:** An employer with fifty or fewer eligible employees on a full or part-time basis**.**

L. **Employer group:** A group of employees employed by an eligible employer who [~~receive~~] receives SCI benefits through the employer.

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

N. **Employer enrollment period:** Employer's standard practice for new and annual health insurance enrollment.

O. **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, as required, as designed by the MCO.

P. **Eligibility letter:** A notice of SCI eligibility and the potential for SCI coverage contingent upon enrollment with a SCI participating MCO. The letter will include start and end dates of eligibility, the requirement to enroll before coverage will begin, and the need to enroll 30 days subsequent to the month of issuance of the enrollment letter. The letter will also notify the member of the federal poverty level subcategory and of the responsibility to track out-of-pocket expenditures for SCI cost sharing.

Q. **Fifth degree of relationship:** The following relatives are within the fifth degree of relationship to a dependent child:

(1) father (biological or adopted);
(2) mother (biological or adopted);
(3) grandfather, great grandfather, great-great-grandfather, great-great-great-grandfather;
(4) grandmother, great grandmother, great-great-grandmother, great-great-great-grandmother;
(5) spouse of child's parent (stepparent);
(6) spouse of child's grandparent, great grandparent, great-great-grandparent, great-great-great-grandparent (step-grandparent);

(7) brother, half-brother, brother-in-law, stepbrother;
(8) sister, half-sister, sister-in-law, stepsister;
(9) uncle of the whole or half blood, uncle-in-law, great uncle, great-great uncle;
(10) aunt of the whole or half-blood, aunt-in-law, great aunt, great-great aunt;
(11) first cousin and spouse of first cousin;
(12) son or daughter of first cousin (first cousin once removed) and spouse;
(13) son or daughter of great aunt or great uncle (first cousin once removed) and spouse; or
(14) nephew/niece and spouses.
(15) ***Note:*** A second cousin is a child of a first cousin once removed or child of a child of a great aunt or uncle and is not within the fifth degree of relationship.

R. **Fiscal agent (medicaid fiscal agent):** An entity contracted by the state medicaid program to sort and process eligibility information as well as pay fee-for-service and capitation claims.

S. **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.

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

U. **Health insurance:** Insurance against loss by sickness or bodily injury. The generic term for any forms of insurance that provides lump sum or periodic payments in the event of bodily injury, sickness, or disease, and medical expense. This includes but is not exclusive of: medicare part A or medicare part B, medicaid, CHAMPUS, and other forms of government health coverage.

V. **Hearing or administrative hearing:** An evidentiary hearing that is conducted so that evidence may be presented.

W. **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.

X. **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 share, if applicable based on household income, and the employer share, or has that amount paid on his/her behalf by another entity.

Y. **Individual health plan**: Health insurance coverage purchased by an individual from an insurer offering individual healthcare benefit policies.

Z. **Managed care organization (MCO):** An organization licensed or authorized through an agreement among state entities to manage and coordinate and receive payment at actuarially sound payment rates for the delivery of specified services to enrolled members from a certain geographic area.

AA. **Member:** An eligible member enrolled in an MCO.

BB. **Member month:** A calendar month in which a member is enrolled in an MCO.

CC. **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.

DD. **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.

EE. **Premium- employer:** A specific monthly payment payable to the MCO by employers who enroll their employees in SCI at a rate set by the department. This amount may be paid by an individual member not in an employer group in order to participate in SCI. Subject to available funding, the state may allocate funds to assist certain eligible individuals with payment of the employer premium contribution and will notify eligible individuals of such assistance. Premiums cannot be refunded.

FF. **Premium- employee:** A specific monthly payment payable to the MCO calculated by the department based on a subcategory of eligibility representing an income grouping. 062-0-100[~~%~~] percent FPL, 062-101-150[~~%~~] percent FPL, 062-151-200[~~%~~] percent FPL. Premiums and copayments cannot be refunded.

GG. **Qualifying event:** Termination of employment for any reason; loss of eligibility for health insurance benefits due to reduction in work hours; loss of health insurance coverage due to death, divorce or legal separation from spouse, loss of dependent status; moving to or from another state.

HH. **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).

II. **Shoebox method:** The method under which an SCI member is responsible for tracking, and submission of a request for verification of total expenditures for himself, based on SCI employee premiums and copayments for purposes of establishing that the cost-sharing maximum amount has been met.

JJ. **Voluntary drop:** The act of voluntarily terminating or discontinuing health insurance coverage.
[8.262.400.7 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 6-1-08; A, 7-1-09]

8.262.400.11 ELIGIBILITY: To be eligible for SCI, an individual must meet all eligibility criteria regarding age, citizenship or alien status, noninsured status (including ineligible for other full coverage medicaid or medicare), voluntary drop of insurance, household income, and living arrangement (i.e., living in a public institution). An eligibility determination will be made by the 45th day after the date of application. If it is determined that an individual does not meet all SCI eligibility criteria, a notice of denial with the reason for denial and rights to appeal will be issued. If it is determined that an individual meets all eligibility criteria, the individual will be awarded an "eligibility letter," which will notify the individual of their right to enroll, and of the fact that coverage will not begin unless and until the individual is enrolled and has paid the determined premium amount, if required, to a SCI-contracted MCO. No partial payments of premiums will be allowed.
[8.262.400.11 NMAC - N, 7-1-05; A, 4-16-07; A/E, 8-1-07; 7-1-09]

8.262.400.13 ENROLLMENT: To be considered enrolled in a given month, an individual must have selected an MCO and become enrolled, and the MCO must consider his premium(s) to be paid. Upon each positive eligibility determination, an enrollment letter will be issued, advising the individual that SCI coverage will begin upon completed enrollment with a SCI-contracted MCO. Individuals have 90 days from the date of approval notice to enroll with the selected MCO. Failure to enroll with the MCO within the 90-day required timeframe may result in closure of program eligibility. Each month, the MCO will provide a roster that includes each enrolled individual. Each SCI-contracted MCO will notify the individual or the employer of the owed premium amount, if required, for the ongoing month. If the premiums are not paid on time, the MCO will send advance notice of closure to the member, prior to termination of coverage due to nonpayment. The MCO will subsequently notify the individual of the termination and the requirements for reenrollment.
[8.262.400.13 NMAC - N, 7-1-05; A/E, 8-1-07; A, 7-1-09]

8.262.400.14 REENROLLMENT:

A. Individual members who have been terminated due to failure to enroll within the required timeframe or to make premium payment or for late payment will be unable to reenroll for a period of six months subsequent to the first month of termination due to failure to enroll or make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. Employer members who have been terminated due to failure to make premium payment or for late payment will be unable to reenroll for a period of [~~twelve~~] 12 months subsequent to the first month of termination due to failure to make premium payments *and* until payment of late or defaulted premiums if so required by the MCO. As a condition of reenrollment an MCO may require an employer to repay overdue premiums as well as require two months premium payments in advance after termination due to nonpayment or late payment.

B. SCI members whose eligibility was closed due to short-term receipt (six months or less) of full coverage medicaid or medicare may have SCI eligibility re-determined and may be able to reenroll with the SCI MCO. Such individuals must meet the following criteria in order to reenroll in SCI:

(1) Must have received full-coverage medicaid or medicare eligibility for six months or less and had such eligibility closed sometime during the six months prior to re-application for SCI;

(2) Must be determined ineligible for full coverage medicaid or medicare; and

(3) Must have had SCI eligibility and completed the enrollment process with an SCI MCO for some period of time during the six months prior to re-application.

C. Upon meeting the above criteria, individuals must submit an updated SCI application, including income information from the most recent past 30 days, to the SCI Income Support Division unit. If determined still eligible for SCI, such individuals may re-enroll with the MCO.
[8.262.400.14 NMAC - N, 7-1-05; A, 7-1-08; A, 7-1-09]

8.262.400.17 SPECIAL RECIPIENT REQUIREMENTS:

A. **Age:** To be eligible for SCI, an individual must be age 19 through 64.

B. **Continuing eligibility on the factor of age:** When an individual has been determined eligible on the condition of age, he remains eligible on the condition until the applicable upper age limit is reached. An

individual who exceeds the age limit during a given month is eligible for that month, unless the birthday is the first day of the month.

C. **Uninsured:** For purposes of SCI eligibility, an individual cannot have health insurance coverage, excluding catastrophic or supplemental health insurance policies. An individual with access to health care at Indian health services, veteran's administration, or through worker's compensation, is not considered to be insured for purposes of this program by having such access.

D. **Enrolled:** An individual who has been determined eligible for SCI must notify an SCI-contracted MCO and must have made and continue to make premium payment as a condition of SCI coverage.

E. **Premium payment**: SCI requires payment of premiums by the employer at a rate established by the department, and by the employee per month as calculated by income level: 062A, 062B and 062C. Some individuals may be required to pay both the employers and employee's share based on income level. Nothing in this section prevents another entity from contributing the employer or employee premium share on behalf of an individual member. Nothing in this section prevents the employer or a third party from paying the employee portion of the premium on behalf of the employee. The due date of premium payments will be determined by the MCO. If an individual's category of SCI eligibility changes at annual recertification for the program, resulting in a different premium payment due, the new premium amount is effective beginning with the first month of the new recertification approval period. Individuals who fail to pay the premium within the timeframe established by the MCO may be disenrolled.

F. **Voluntary drop of health insurance:** An individual who has voluntarily dropped health insurance will be ineligible for SCI for six months, starting with the first month the health insurance was dropped (i.e., the first month of no coverage). An employer who has voluntarily dropped health insurance will be ineligible to enroll employees in SCI for twelve months. The following circumstances are not considered a voluntary drop:

(1) an individual (or spouse) fails to take advantage of an initial offer of health insurance by an employer (unless the insurance is SCI coverage), or fails or refuses to take advantage of a COBRA continuation policy;

(2) loss of access to employer-sponsored insurance due to loss of employment, divorce, death of a spouse, or geographic move, loss of coverage as a dependent child, or loss of medicaid eligibility; or

(3) an employee enrolled in an individual health plan whose employer is offering SCI employer-sponsored insurance (as an initial offering or at open enrollment) will be able to participate in SCI under group coverage and will not be considered to have voluntarily dropped health insurance in order to participate in the SCI employer group plan.

G. **Cost-sharing maximums:** An SCI-covered individual is responsible for tracking and reporting of the cost-sharing amount paid in a benefit year, and for reporting to the managed care organization (MCO) when the cost-sharing maximum amounts are met (also known as "shoebox methodology"). The first month of coverage without cost-sharing will be the month after the month of verification that the maximum expenditure limit has been met, unless the determination is made after the 24th of the month. Where the determination is made after the 24th of the month, the first month of coverage without cost-sharing will be the second month after verification. The period of coverage without cost-sharing will end on the last day of that benefit year. No partial payments of premiums or of copayments will be allowed. No premiums or copayments will be refunded.

[8.262.400.17 NMAC - N, 7-1-05; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.262.400.19 NON-CONCURRENT RECEIPT OF ASSISTANCE: An SCI applicant/recipient cannot be simultaneously approved for any of the other New Mexico medicaid categories, any kind of partial or full medicare coverage, or for any medicaid program in another state. If the SCI member is given retroactive eligibility for medicaid or medicare, SCI premiums and copayments paid by the member will not be refunded for the months in which the client was later found to be retroactively eligible [~~for medicaid~~].

[8.262.400.19 NMAC - N, 7-1-05; A, 4-16-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 500 INCOME AND RESOURCE STANDARDS

8.262.500.9 ESTABLISHING NEED - GENERAL REQUIREMENTS: Methodology for establishing financial eligibility for state coverage insurance (SCI) uses New Mexico works cash assistance definitions of income, rules for income availability, and exempt income with the exception of Subsection C of 8.102.520.11NMAC and Subsection B of 8.102.520.12 NMAC, which refer to the methodology for determining self-employment income.

A. **Income test:** In order to be eligible for SCI, countable income (after applicable exemptions and disregards) must meet the SCI household income limit for the appropriate family size. The SCI income standards are based on 200[~~%~~] percent of federal poverty levels (FPLs). SCI uses New Mexico works income definitions and methodologies with the exception of Subsection C of 8.102.520.11NMAC and Subsection B of 8.102.520.12 NMAC. (Also see 8.102.520.8 NMAC through 8.102.520.15 NMAC). SCI eligibility and cost-sharing levels will be determined based on one income test using countable income (after applicable exemptions and disregards).

B. **Determining income for self-employed individuals:** Reports to state and federal tax authorities are the usual indicators of self-employment income (refer to Subparagraph (b) of Paragraph (2) of Subsection B of 8.100.130.14 NMAC for other acceptable documents that may be submitted to determine self-employment income). To determine self-employment income, apply the following methodology:

(1) use the amount listed on line 31 (net profit or loss) of schedule C or line 36 (net profit or loss) of Schedule F, or the net profit/loss line of other schedules deemed applicable to self-employment income, of the most recent or previous year's 1040 income tax return to determine annual self-employment income;

(2) divide the amount by 12 or by the applicable number of months in business to determine monthly self-employment income.

C. **Payment standard increments:** Payment standard increments for nonsubsidized housing living arrangements and clothing allowance do not affect the SCI eligibility process, i.e., the eligibility limits for income are not increased by the amount of the nonsubsidized housing or clothing allowance payment increments.

D. **Excess hours work deduction:** This deduction is not applicable to SCI.

E. **SCI category designation:** SCI eligibles will be assigned one category of eligibility (062). The income grouping (subcategory) will control the employee premium and copayment amounts.

[8.262.500.9 NMAC - N, 7-1-05; A, 3-1-06; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 262 MEDICAID ELIGIBILITY - STATE COVERAGE INSURANCE (SCI) (CATEGORY 062)
PART 600 BENEFIT DESCRIPTION

8.262.600.9 BENEFIT DESCRIPTION: The benefit package is described in 8.306.7. NMAC, *Benefit Package*, SCI benefits are administered by contracted managed care organizations. There is no fee-for-service coverage under the SCI program.

A. The level of cost-sharing (i.e., the premium and co-payment amounts as well as the cost-sharing maximum amounts) required in the SCI program is contingent upon the income grouping associated with the applicant's countable household income at the point of the application disposition. See also 8.262.500.9 NMAC.

B. The cost-sharing maximum is an amount calculated for the benefit year that represents an amount equal to [~~5%~~] five percent of the [~~enrollee~~] enrollee's countable household income at the time of the application disposition. It is the responsibility of each SCI-covered individual to track and total the amounts paid for the SCI employee portion of the premiums and SCI co-payments on SCI-covered services in a benefit year. Once the cost-sharing maximum amount has been paid by an SCI-covered individual, the individual must notify the MCO and provide verification of the paid amounts. Once the paid amounts have been verified as paid, the individual will not owe further employee premium or co-payment amounts for the remainder of that benefit year. The first month that cost sharing is not required by the SCI-covered individual is the month following the month in which it has been verified by the MCO that the cost-sharing maximum amount has been met. If the determination is made after the 24th of the month, the change is made effective the second month after the verification. No retroactive eligibility for the "met cost-sharing maximum" amount is allowed. The employer portion of the premium is not counted toward the cost-sharing maximum and must be paid by (or on behalf of) the individual enrollee each month regardless of income category or cost-sharing maximum status. Premium payments must be paid in full each month, even if the cost-sharing maximum has been reached and there is an overpayment. No partial payments of premiums or copayments will be allowed. No premiums or copayments will be refunded.

C. Employer share payable by individual: An individual member (one who is enrolled outside of an employer group) may be responsible for payment of the premium share for the employee as determined by federal poverty level and the employer premium. The employer portion of the premiums will not be counted toward the cost-sharing maximum.

[8.262.600.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.262.600.11 CONTINUOUS ELIGIBILITY: Eligibility will continue for the[~~twelve~~] 12-month certification period, regardless of changes in household income, as long as the individual retains New Mexico residency and continues to be ineligible for other medicaid or medicare coverage and is less than 65 years of age. Twelve-month continuous eligibility shall not be affected by the disposition of any other benefit(s) such as TANF, food stamps, etc. HSD will notify members, whether employees enrolled through an employer group or individuals, [~~forty-five (45)~~] 45 days prior to the end of the recertification period. Members are responsible for recertifying eligibility within the [~~forty-five (45)~~] 45 day period prior to expiration of the eligibility certification period and notifying the MCO or the employer of their interest in recertification. Failure of the member to follow up with his/her recertification responsibilities within the required timeframe, including the submission of updated income documents, may result in termination from the SCI program.

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

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

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[~~, including co-occurring disorders~~].

(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 [~~with multiple, complex and special cognitive, behavioral or physical health care needs~~] "at risk" for adverse outcomes to help meet their needs by filling in gaps in current health care on an as needed basis. [~~It~~] Care coordination is member-centered, family-focused when appropriate, culturally competent and strengths-based[~~. Care coordination can help to~~], and [~~ensure~~] ensures that the [~~physical~~] medical and behavioral health needs of the SCI population are identified and services are provided and coordinated with the [~~individual~~] member and family, [~~if~~] 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 [~~, functioning independently,~~] 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, [~~if applicable, for those who receive~~] or refer the member to case management [~~services~~] as necessary. If both physical and behavioral health conditions exist, the primary care coordination responsibility [~~will~~] [~~lie~~] lies with [~~the care provider from~~] the condition that is most acute [~~at the time~~].

(3) **Case management**: Case management consists of services which help beneficiaries gain access to needed physical health, behavioral health, social, educational, and other services; [~~Refers to~~] 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) **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.

(6) **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".

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

(8) **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.

(9) **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.

[~~(8)~~] (10) **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.

[~~(9)~~] (11) **[~~Coordinated~~] Coordination of long-term services ~~(CLTS)~~ (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 [~~CLTS~~] 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 [~~CLTS~~] CoLTS program does not include individuals who meet eligibility criteria set forth in New Mexico's developmental disabilities and medically-fragile waiver programs.

[~~(10~~] (12) **Cost-sharing:** Premiums and co-payments owed by the member based on income group category.

[~~(11)~~] (13) **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 5% of the program participant's countable household income.

[~~(12)~~] (14) **Coverage:** Coverage month is a month where all eligibility and enrollment requirements including premium payment, if applicable are met.

[~~(13)~~] (15) **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[~~, except pharmaceutical services which the formulary process covers~~].

(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 fifty 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%, 101-150%, and 151-200% 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, [~~as well as~~] 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 share, if applicable, based on household income, and the employer share 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.

[~~(4)~~] (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.

[~~(5)~~] (6) **Member:** A eligible member enrolled in an MCO.

[~~(6)~~] (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) **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.

(2) **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.

(3) **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.

[~~(3)~~] (4) **Performance measurement (PM):** Data specified by the state that enables the MCO's performance to be determined.

[~~(4)~~] (5) **Plan of care:** A written document including all medically necessary services to be provided by the MCO for a specific member.

[~~(5)~~] (6) **Policy:** The statement or description of requirements.

[~~(6)~~] (7) **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.

[~~(7)~~] (8) **Pregnancy-related services:** Medically necessary medical or surgical services related to pregnancy, including procedures to terminate pregnancy.

[~~(8)~~] (9) **Preventative health services:** Services that follow current national standards for prevention including both physical and behavioral health.

[~~(9)~~] (10) **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.

[~~(10)~~] (11) **Primary care provider (PCP):** A provider who agrees to manage and coordinate the care provided to members in the managed care program.

[~~(11)~~] (12) **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.

[~~(1)~~] (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).

[~~(2)~~] (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.

[~~(3)~~] (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."

[~~(4)~~] (5) **Subcontract:** A written agreement between the MCO and a third party, or between a subcontractor and another subcontractor, to provide services.

[~~(5)~~] (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]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 2 MEMBER EDUCATION

8.306.2.9 MEMBER EDUCATION: SCI members shall be advised of their rights, responsibilities, service availability and administrative roles under SCI. Member education is initiated when a member becomes eligible for SCI with information provided by HSD and the managed care organization (MCO).

A. **Initial information:** Various outreach and media strategies are designed to reach employers, employees, as well as non-employed individuals; to ensure that all eligible New Mexicans are aware of the availability of SCI. Marketing is especially targeted to employers not currently offering insurance as well as to employers who offer insurance but whose employees cannot afford the required premium sharing. Initial member education is provided by the MCO and brokers and through outreach materials available from HSD.

B. **MCO enrollment information:** Once an individual enrollee or employee is determined to be eligible for the SCI program, his employer, broker, or MCO will provide the member information about services included in the MCO benefit package.

C. **Informational materials:** The MCO is responsible for providing members and potential members, upon request, a member handbook and a provider directory. The member handbook and the provider directory shall be available in languages other than English, if there is a greater than 5% incidence of another language spoken within the MCO membership as determined by the MCO or HSD.

(1) The member handbook shall include the following:

(a) MCO demographic information, including the organization's hotline telephone number;

(b) information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent;

(c) patient bill of rights and member responsibilities, including any restrictions on the member's freedom of choice among network providers;

(d) information pertaining to coordination of care by and with PCPs;

(e) how to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services;

(f) [~~description~~] the amount, duration and scope of benefits;

(g) information on accessing behavioral health or other specialty services,

(h) limitations to the receipt of care from out-of-network providers for non-emergency care;

(i) a list of services for which prior authorization or a referral is required and the method of obtaining both;

(j) a policy on referrals for specialty care and other benefits not furnished by the member's PCP;

(k) notice to members about the grievance process and about HSD's fair hearing process;

(l) information on the member's right to terminate enrollment and the process for voluntarily disenrolling from the plan;

(m) information regarding advance directives;

(n) information regarding obtaining a second medical opinion;

(o) information on cost sharing, cost sharing maximums and maximum benefit amounts per benefit year[~~.~~];

(p) how to obtain information, determined by HSD as essential during the member's initial contact with the MCO, which may include a request for information regarding the MCO's structure, operation, and physician's or senior staff's incentive plans[~~,~~]; and

(q) language that clearly explains that a Native American SCI member may self refer to an Indian health service or Tribal health care facility for services and is exempt from co-payment requirements.

(2) The provider directory shall include the following:

(a) MCO addresses and telephone numbers;

(b) a listing of primary care and self-refer specialty providers with the name, location, phone number, and qualifications including areas of special expertise and non-English languages spoken that would be helpful to members; MCO-contracted specialty providers for self-referral shall include, but not be limited to, [~~family planning providers,~~] point-of-entry behavioral health providers, urgent and emergency care providers, Indian health service, and [~~other Native American~~] Tribal health care providers [~~and pharmacies~~] including hospitals, outpatient clinics, and pharmacies; and

(c) the material shall be available in a manner and format that can be easily understood by all populations who exceed a greater than [~~5%~~] five percent incidence in the total MCO membership as identified by the MCO and HSD.

D. **Other requirements:**

(1) The MCO shall provide the member handbook and provider directory to enrolled members within 30 calendar days of enrollment.

(2) The handbook and directory shall be provided in a comprehensive, understandable format that takes into consideration the special needs population, is in accordance with federal mandates and meets communication requirements delineated in 8.305.8.15 NMAC, *Member Bill of Rights*. This information may also be accessible via the internet and be provided as requested by HSD. The MCO shall have a process in place for notifying members of the availability of this information in alternative formats.

(3) Oral and sign language interpretation shall be made available free of charge to members and to potential members, upon request, and be available in non-English languages for populations that exceed a greater than [~~5%~~] five percent incidence within the MCO's membership as defined by the MCO and HSD.

(4) The member handbook shall be approved by HSD prior to distribution to SCI members.

(5) Notification of material changes in the administration of the MCO changes in the MCO's provider network, significant changes in applicable state law, and any other information deemed relevant by HSD shall be distributed to the members [~~thirty days (30)~~] 30 prior to the intended effective date of the change. In addition, the MCO shall make a good faith effort to give written notice of termination of a contracted provider within 15 days after receipt or issuance of a termination notice.

(6) Notification to members about any of these changes may be made without reprinting the entire handbook.

(7) The MCO shall notify all members at least once per year of their right to request and obtain member handbooks and provider directories.

E. **MCO policies and procedures on member education:** The MCO shall maintain policies and procedures governing the development and distribution of educational material for members. Policies shall address how members and potential members receive information, the means of dissemination and the content, comprehension level and languages used. The MCO shall have written policies and procedures regarding the utilization of information on race, ethnicity and primary language spoken by its membership.

F. **Health education:** The MCO shall provide a continuous program of health education without cost to members. Such a program may include publications (brochures, newsletters), electronic media (films, videotapes), presentations (seminars, lunch-and-learn sessions) and classroom instruction. The MCO shall provide programs of wellness education, including programs provided to address the social, physical, behavioral and emotional consequences of high-risk behaviors. HSD approval of health education materials is not required.

G. **Maintenance of toll-free line:** The MCO shall maintain one or more toll-free telephone lines that are accessible 24 hours a day, seven days a week, to facilitate member access to a qualified clinical staff to answer health-related questions. MCO members may also leave voice mail messages to obtain other MCO policy information and to register grievances with the MCO. The MCO shall return the telephone call by the next business day.

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

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 3 CONTRACT MANAGEMENT

8.306.3.10 CONTRACT MANAGEMENT:

A. **General contract requirements:** The MCOs shall meet all specified terms of the SCI contract and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO will be held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD. HSD is responsible for management of the SCI managed care contracts issued to MCOs. HSD shall provide the oversight and administrative functions to ensure MCO compliance with the terms of the SCI managed care contract.

B. **Subcontracting requirements:** The MCO may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO [~~function~~] functions with HSD's approval. The MCO shall be legally responsible to HSD for all work performed by any MCO subcontractor. The MCO shall submit boilerplate contract language and sample contracts for various types of subcontracts

(1) **Credentialing requirements:** The MCO shall maintain policies and procedures for verifying for HSD's approval. Any substantive changes to contract templates shall be approved by HSD prior to issuance.that the credentials of its providers and subcontractors meet applicable standards.

(2) **Review requirements:** The MCO shall maintain a fully executed original of all subcontracts and make them available to HSD on request.

(3) **Minimum requirements:** Subcontracts shall contain the following provisions:

(a) subcontracts shall be executed in accordance with applicable federal and state laws, regulations, policies and rules;

(b) subcontracts shall identify the parties of the subcontract and the parties' legal basis [~~of operation~~] to operate in the state of New Mexico;

(c) subcontracts shall include [~~procedures and criteria for terminating the subcontract~~] the frequency of reporting (if applicable) to the MCO and the process by which the MCO evaluates the delegate;

(d) subcontracts shall identify the services to be performed by the subcontractor including a description of how members access services provided under the subcontract;

(e) subcontracts shall include reimbursement rates and risk assumption, where applicable;

(f) subcontractors shall maintain records relating to services provided to members for ten years;

(g) subcontracts shall require that member information be kept confidential, as defined by federal or state law and be HIPAA compliant;

(h) subcontracts shall provide that authorized representatives of HSD have reasonable access to facilities, personnel and records for financial and medical audit purposes;

(i) subcontracts shall [~~provide~~] include a provision for the subcontractor to release to the MCO any information necessary to perform any of its obligations;

(j) the subcontractor shall accept payment from the MCO for any services provided under the benefit package and may not request payment from HSD for services performed under the subcontract;

(k) if the subcontract includes primary care, the subcontractor shall comply with PCP requirements delineated in the MCO contract with HSD;

(l) the subcontractor shall comply with all applicable state and federal statutes, rules and regulations, including prohibitions against discrimination;

(m) subcontracts shall have procedures and criteria for terminating the subcontract and provisions for the imposition of sanctions for inadequate subcontractor performance and for terminating, rescinding, or canceling the contracts for violation of applicable HSD requirements;

[~~(m)~~](n) the subcontract shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO;

(o) subcontracts may not include incentives or disincentives that encourage a provider or other subcontractor not to enter into a contractual relationship with another MCO;

[~~(n)~~] (p) [~~the subcontract shall allow~~] subcontracts shall not contain any gag order provisions nor sanctions against providers [~~to~~] who assist members [~~to~~] in [~~access~~] accessing the grievance process or [~~to act to~~] otherwise act to protect [~~member~~] members' interests;

[~~(o)~~] (q) [~~the subcontract~~] subcontracts shall specify the time frame for submission of encounter data to the MCO;

[~~(p)~~] (r) subcontracts to entities that receive annual medicaid payments of at least $5 million shall include detailed information regarding employee education of the New Mexico and federal False Claims Act; [~~and~~]

[~~(q)~~] (s) subcontracts shall include a provision requiring the [~~subcontractor~~] subcontractors to perform criminal background checks for all required individuals providing services[~~.~~]

(t) subcontracts shall include a provision requiring providers to submit claims electronically. Low volume or low dollar providers may have this requirement waived; and

(u) subcontracts shall include the HSD contractual provisions of the State of New Mexico Executive Order 2007-049 concerning subcontractor health coverage requirements.

(4) **Excluded providers:** The MCO shall not contract with any individual provider, or entity, or entity with an officer, director, agent, or manager who owns or has a controlling interest in the entity, who has been convicted of crimes specified in Section 1128 of the Social Security Act; has been excluded from participation in any other state's medicaid, medicare, or any other public or private health or health insurance program; has been assessed a civil penalty under the provision of Section 1128; or who has had a contractual relationship with an entity or individual convicted of a crime specified in Section 1128.

C. **Provider incentive plans:** The MCO shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members.

[8.306.3.10 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; 7-1-09]

8.306.3.11 ORGANIZATIONAL REQUIREMENTS:

A. **Organizational structure:** The MCO shall provide the following information to HSD and updates, modifications, or amendments to HSD within 30 days:

(1) current organization charts or other written plans identifying organizational lines of accountability;

(2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the MCO's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and

(3) documents describing the MCO's relationship to parent-affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

B. **Policies, procedures and job descriptions:** The MCO shall establish and maintain written policies, procedures and job descriptions as required by HSD. The MCO shall establish, maintain and implement guidelines for developing, reviewing and approving policies, procedures and job descriptions. The MCO shall provide MCO policies, procedures, and job descriptions for key personnel and guidelines for review to HSD on request. The MCO shall notify HSD within 30 days when changes occur in key personnel.

(1) **Review of policies and procedures:** The MCO shall review the MCO's policies and procedures at least every two years, unless otherwise specified herein, to ensure that they reflect the MCO's current best industry practices. Job descriptions shall be reviewed to ensure that current employee duties reflect written requirements. Substantive modification or amendment to key positions shall be reviewed by HSD.

(2) **Distribution of information:** The MCO shall distribute to providers information necessary to ensure that providers meet all contract requirements.

(3) **Business requirements:** The MCO shall have the administrative, information and other systems in place necessary to fulfill the terms of the SCI managed care contract. Any change in identified key MCO personnel shall conform to the requirements of the SCI managed care contract. The MCO shall retain financial records, supporting documents, statistical records, and all other records for a period of 10 years from the date of submission of the final expenditure report, except as specified by HSD.

(4) **Financial requirements:** The MCO shall meet the requirements of federal and state law with respect to solvency and performance guarantees for the duration of the SCI managed care contract. The MCO shall meet additional financial requirements specified in the SCI managed care contract.

(5) **Member services:** The MCO shall have a member services function that coordinates communication with members and acts as a member advocate. Member services shall include sufficient staff to assist members in resolving problems or making inquiries. The MCO's policies and procedures shall be made available on request to members or member representatives for review during normal business hours.

(6) **Consumer advisory board:** [~~The MCO shall establish representation on its current medicaid managed care consumer advisory board that includes SCI. This representation may have regional representation of~~

~~[customers] consumers, family members, advocates and providers who participate in SCI. The MCO can also devise a method, approved by HSD/MAD, to elicit feedback from SCI consumers and address their needs, if~~] The consumer advisory board shall consist of a fair representation of the MCO's members and include regional representation of members, advocates and providers. If formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members, the MCO shall include at least three SCI members in the Salud! consumer advisory board meetings.

(a) Consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board [~~members~~] membership as they pertain to SCI. The MCO will hold quarterly centralized meetings during the year and keep a written record of meetings. The board roster and minutes shall be made available to HSD on request. The MCO shall advise HSD at least 10 days in advance of meetings to be held. HSD shall attend and observe the MCO's consumer board meetings at its discretion.

(b) The MCO [~~shall attend at least two statewide consumer-driven or hosted~~] will hold two regional consumer advisory board meetings[~~, relevant to the SCI population,~~] per contract year[~~, of the MCO's choosing,~~] that focus on consumer issues and needs to ensure that member's concerns are heard and addressed. Attendance rosters and minutes for these two regional meetings shall be made available to HSD.

(7) **Requirements for Native American membership:** Per HSD direction, the MCO shall hold at least one annual meeting with Native American representatives from around the state of New Mexico who represent membership demographics. The minutes of such meetings shall be submitted to HSD within 30 days of such meetings.

C. **Contract enforcement:** HSD shall enforce contractual and state and federal regulatory requirements specified in the scope of work of the contract. HSD may use the following types of sanctions for less than satisfactory or nonperformance of contract provisions:

[~~(a)~~] (1) require plans of correction;

[~~(b)~~] (2) impose directed plans of correction;

[~~(c) impose civil or administrative monetary penalties and fines under the following guidelines:~~]

(3) impose monetary penalties to the extent authorized by federal or state law:

(a) HSD retains the right to apply progressively stricter sanctions against the MCO, including an assessment of a monetary penalty against the MCO, for failure to perform in any contract area;

(b) unless otherwise required by law, the level of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or the integrity of the SCI program;

(c) a monetary penalty, depending on the severity of the infraction; penalty assessments shall range up to five percent of the MCO's SCI capitation payment in the month in which the penalty is assessed;

(d) any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the MCO to interrupt services provided to members; and

(e) all administrative, contractual or legal remedies available to HSD shall be employed in the event that the MCO violates or breaches the terms of the contract.

(4) impose other civil or administrative monetary penalties and fines under the following guidelines:

[~~(i)~~] (a) a maximum of $25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;

[~~(ii)~~] (b) a maximum of $100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD[~~,~~] or CMS;

[~~(iii)~~] (c) a maximum of $15,000.00 for each SCI member that HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of $100,000.00; and

[~~(iv)~~] (d) a maximum of $25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the SCI program; the state shall deduct from the penalty the amount of overcharge and return it to the affected [~~enrollee~~] enrollees[~~; and~~].

[~~d~~] (5) rescind marketing consent;

[~~(e)~~] (6) suspend new enrollment, including default enrollment after the effective date of the sanction;

[~~(f)~~] (7) appoint a state monitor, the cost of which shall be borne by the MCO;

[~~(g)~~] (8) deny payment [~~of capitation rates~~];

[~~(h)~~] (9) assess actual damages;

[~~(i)~~] (10) assess liquidated damages;

[~~(j)~~] (11) remove members with third party coverage from enrollment with the MCO;

[~~(k)~~] (12) allow members to terminate enrollment;

[~~(l)~~] (13) suspend or terminate MCO contract;

[~~(m)~~] (14) apply other sanctions and remedies specified by HSD; and

[~~(n)~~] (15) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that:

[~~(i)~~] (a) there is continued egregious behavior by the MCO, including but not limited to [~~as~~] behavior that is described under [~~sub-paragraph (c)~~] paragraph (4) above [~~including but not limited to behavior that is prohibited under specific federal law granting states appropriations for medicaid services,~~]or that is contrary to any requirements of 42 USC Sections 1396b(m) or 1396u-2; or

[~~ii~~] (b) there is substantial risk to member's health; or

[~~iii~~] (c) the sanction is necessary to ensure the health and safety of the MCO's members while improvement is made to remedy violations made under [~~Subparagraph (c)~~] paragraph (4) above; or until there is orderly termination or reorganization of the MCO; and

[~~iv~~] (d) [~~there shall be no provision for hearing prior to the imposition of temporary management and;~~] HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction; HSD shall not terminate temporary management until it determines that the MCO can ensure that the sanctioned behavior will not re-occur; refer to state and federal regulations for due process procedures.

[8.306.3.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 4 ELIGIBILITY

8.306.4.11 MANAGED CARE STATUS CHANGE: A change of SCI eligibility for a member enrolled in an MCO may result in managed care disenrollment or change of enrollment status within the MCO, including but not limited to receipt of medicaid or medicare, which may be provided retroactively; failure to complete annual recertification for the program; or failure to make required premium payments.
[8.306.4.11 NMAC - N, 7-1-05; A, 7-1-09

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 5 ENROLLMENT

8.306.5.9 ENROLLMENT PROCESS:

A. **Enrollment requirements:** The managed care organization (MCO) shall provide an open enrollment period during which the MCO will enroll individuals in accordance with accepted MCO practice in the order in which they apply, up to the limits contained in the contract. The MCO shall not discriminate on the basis of health status or a need for health care services. The MCO shall not discriminate against individuals eligible to enroll on the basis of disability, race, color, national origin, or sexual orientation. The MCO shall not use any policy or practice that has the effect of discriminating on the basis of disability, race, color, national origin, or sexual orientation. All enrollments shall be voluntary and based on member or employer choice.

B. **Member lock-in:** Except as otherwise provided below, once a member in an employer group has enrolled in an MCO through his employer group, he may only transfer to another MCO, 1) during the employer enrollment period, that occurs when the employer contracts with another MCO; or 2) if he changes employers. A member enrolled individually may only transfer to another MCO when his eligibility is recertified or "for cause" as defined as follows: the following criteria shall be cause for transfer:

(1) continuity of care issues;
(2) family continuity;
(3) administrative or data entry error in assigning a client to an MCO;
(4) assignment of a member where travel for primary care exceeds community standards (90[~~%~~] percent of urban residents shall travel no further than 30 miles to see a PCP; 90[~~%~~] percent of rural residents shall travel no further than 45 miles to see a PCP; and 90[~~%~~] percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;
(5) the member moves out of the MCO service area;
(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;
(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and
(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

C. **Selection period:** After receiving a letter of eligibility from the ISD office or an enrollment packet from the MCO, a new individual member shall complete enrollment with an MCO within a [~~30~~] 90 day period. If enrollment, including payment of any required premium, is not made within that timeframe, the member shall be considered to have voluntarily dropped the SCI insurance coverage, which means that the individual[~~,~~] may not enroll with an SCI MCO for six months. An employer group has a specified time period, determined by the MCO and HSD, in which to complete enrollment and premium payment with an SCI MCO after all employees have received their letters of eligibility. Failure of the employer to complete the enrollment process within this time period will deem the employer to have voluntarily dropped insurance coverage and the employer will be ineligible to enroll with an SCI MCO for a [~~twelve~~] 12-month period; however, the individual employees are eligible to enroll immediately as individuals and will not be considered to have voluntarily dropped health insurance coverage.

D. **Beginning date of enrollment:** Enrollment begins the first day of the first full month following receipt of eligibility letter and MCO completion of enrollment including receipt of required premiums. However, if MCO receipt of required premium payment occurs after the HSD-approved designated day of the month and before the first full day of the following month, the enrollment begins on the first day of the second full month after MCO receipt of premium payments.

E. **Member switch enrollment:** A member enrolled as an individual and not as an employee enrolled through an employer group may request to be disenrolled from an MCO and switch to another MCO (if available) "for cause" at any time. The request shall be made in writing to HSD. HSD shall review the request and

furnish a written response to the member and the MCO in a 30 day period. The following criteria shall be used to make a decision regarding a switch enrollment request:

(1) continuity of care issues;

(2) family continuity;

(3) administrative or data entry error in enrolling a member with an MCO;

(4) travel for primary care exceeds community standards, (90[~~%~~] percent of urban residents shall travel no further than 30 miles to see a PCP; 90[~~%~~] percent of rural residents shall travel no further than 45 miles to see a PCP; and 90[~~%~~] percent of frontier residents shall travel no further than 60 miles to see a PCP); urban counties are: Bernalillo, Los Alamos, Santa Fe and Dona Ana; frontier counties are: Catron, Harding, DeBaca, Union, Guadalupe, Hidalgo, Socorro, Mora, Sierra, Lincoln, Torrance, Colfax, Quay, San Miguel and Cibola; rural counties are those which are not listed as urban or frontier;

(5) the member moves out of the MCO service area;

(6) the MCO does not, because of moral or religious objections, cover the service the member seeks;

(7) the member needs related services to be performed at the same time, not all related services can be provided by the PCP, and another provider determines that receiving the services separately would subject the member to unnecessary risk; and

(8) other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs; if applicable, the member shall be notified by the MCO, 60 days prior to the expiration of the member's lock-in period of the deadline for selecting a new MCO; members in an employer group will be notified of the employer enrollment period by the employer or the broker, if applicable; members who are not in an employer group will be notified of the expiration of their lock-in period by the MCO.

F. **Disenrollment, MCO initiated:** The MCO may request that a particular member be disenrolled. Other than for non-payment of premiums, member disenrollment from an MCO will be considered only in rare circumstances. Disenrollment requests shall be made in writing to HSD. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter to HSD. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another SCI- contracted MCO. If the member is part of an employer group and the employer does not contract with another MCO, HSD may allow the member to enroll with another MCO, but the member shall be responsible for the employer's premium share, if required. The MCO shall assist with transition of care to the other MCO.

G. **Conditions under which an MCO requests member disenrollment:** The MCO may not seek to terminate enrollment because of an adverse change in the member's health. The MCO shall not request disenrollment because of an adverse change in the member's health status or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his special needs, except when his continued enrollment with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members. The MCO shall notify the member in writing of the disenrollment request at the same time the request is submitted to HSD. The MCO shall submit a copy of the member's notification letter. If the disenrollment is granted, the MCO retains responsibility for the member's care until the member is enrolled with another MCO. The MCO shall assist with transition of care.

H. **Re-enrollment limitations:** If a request for disenrollment is approved, the member shall not be re-enrolled with the requesting MCO for a period of time to be determined by HSD. The member and the requesting MCO shall be notified by HSD of the period of disenrollment. If a member has been disenrolled by all available contracted MCOs, HSD shall evaluate the member for termination from SCI.

I. **Date of disenrollment:** MCO enrollment shall terminate at the end of the month following the month in which HSD approval for disenrollment is granted.

[8.306.5.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A/E, 8-1-07; A, 7-1-09]

8.306.5.13 MASS TRANSFER PROCESS: The mass transfer process is initiated when HSD determines that the transfer of MCO members from one MCO to another is appropriate.

A. **Triggering mass transfer process:** The mass transfer process may be triggered by two situations:

(1) a maintenance change, such as changes in MCO identification number or MCO name; and

(2) a significant change in MCO contracting status, including but not limited to, loss of licensure, substandard care, fiscal insolvency or significant loss in network providers.

B. **Effective date of mass transfer:** The change in enrollment initiated by the mass transfer begins with the first day of the month following the identification of the need to transfer MCO members.

C. **Member selection period:** Following a mass transfer, MCO members or employers as applicable are given an opportunity to select a different MCO, if available.

D. **Mass transfer based on significant change in contracting status:** The mass transfer function is triggered when the MCO's contract status changes and the change may be significant to the MCO member. Upon initiation of the mass transfer function by HSD, [~~MCO members are transferred to a different MCO and~~] a notice is sent to members informing them of the transfer and their opportunity to select a different MCO, if available. HSD will work with employers to contract with the new MCO(s).

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

8.306.5.14 SCI MARKETING-OUTREACH GUIDELINES: When marketing to SCI members, the MCOs shall follow the SCI marketing guidelines.

A. **Minimum marketing and outreach requirements:** Marketing is defined as the act or process of promoting a business or commodity. The marketing and outreach material shall meet the following minimum requirements:

(1) marketing and outreach materials shall meet requirements for all communication with SCI members, as required in the quality standards (8.305.8.15 NMAC, *Member Bill of Rights*) and incorporated into the managed care contract;

(2) all marketing or outreach materials produced by the MCO under the SCI contract shall state that such services are funded in part under contract with the state of New Mexico;

(3) marketing and outreach information provided to members shall be accurate, not misleading, and non-threatening;

(4) if there is a population of greater than [~~5%~~] five percent in the MCO membership, as identified by the MCO and HSD, that has limited English proficiency, as identified by the MCO or HSD, marketing materials shall be available in the language of that population; and

(5) other requirements specified by the state.

B. **Scope of marketing guidelines:** Marketing materials are defined as brochures and leaflets; newspaper, magazine, radio, television, billboard, and MCO yellow page advertisement, press releases, telephone scripts, [and] web site and presentation materials used by an MCO, [~~and~~] an MCO representative or an MCO sub-contractor to attract and retain SCI enrollment. HSD may request, review and approve or disapprove any communication to any SCI member. HSD may request, review and approve or disapprove any communication to any SCI member regarding behavioral health. The [~~MCOs~~] MCO [~~are~~] is not restricted by HSD in their general communications to the public. HSD shall approve advertisements mailed to, distributed to, or aimed at SCI members and marketing material that mentions SCI, medicaid, medical assistance, Title XIX , Title XXI or Salud! or makes reference to medicaid behavioral health services. The MCO shall notify HSD of significant format changes to advertisements. Examples of medicaid-specific materials would be those that:

(1) are in any way targeted to SCI populations, such as billboards or bus posters disproportionately located in low-income neighborhoods; or

(2) contain language or information designed to attract SCI enrollment.

C. **Advertising and marketing material:** Medicaid-specific advertising and marketing materials, including materials disseminated by a sub-contractor and information disseminated via the internet requires HSD approval. In reviewing this information, HSD shall apply a variety of criteria.

(1) **Accuracy:** The content of the material shall be accurate. Information deemed inaccurate shall be disallowed.

(2) **Misleading references:** Misleading information about the MCO shall not be allowed even if it is accurate.

D. **Marketing and outreach activities not permitted:** The following marketing and outreach activities are not permitted regardless of the method of communication (oral, written or other means of communication) or whether the activity is performed by the MCO directly, its network providers, its subcontractors or any other party affiliated with the MCO. HSD may prohibit additional marketing activities at its discretion.

(1) asserting or implying that a member will lose SCI benefits if he does not enroll with the MCO or creating other scenarios that do not accurately depict the consequences of choosing a different MCO;

(2) designing a marketing or outreach plan that discourages or encourages MCO selection based on a potential member's health status or risk;

(3) making inaccurate, misleading or exaggerated statements designed to recruit a potential member;

(4) asserting or implying that the MCO offers unique covered services when another MCO provides the same or similar services;

(5) the use of more than nominal gifts, such as diapers, toasters, infant formula or other incentives to entice members to join a specific health plan;

(6) telemarketing or other cold call marketing with potential members;

(7) conducting any other marketing activity prohibited by HSD;

(8) explicit direct marketing to members enrolled with other MCOs unless the member requests the information;

(9) distributing any marketing materials without first obtaining HSD approval;

(10) seeking to influence enrollment in conjunction with the sale or offering of any private insurance except in the instance of combination groups that offer commercial coverage and SCI to those employees who may qualify;

(11) engaging in telephone or other cold call marketing activities, directly or indirectly; and

(12) other requirements specified by HSD.

E. **Marketing in current care sites:** Promotional materials may be made available to members and potential MCO enrollees in care delivery sites, including patient waiting areas, if HSD has prior approved the content. Face-to-face meetings with MCO staff, at health care delivery sites, for the purpose of marketing to potential enrollees shall not be permitted.

F. **Provider communications with medicaid members about MCO options:** HSD marketing restrictions shall apply to MCO subcontractors and providers as well as to the MCO. MCOs are required to notify participating providers of the HSD marketing restrictions, including providing a copy of these regulations. HSD shall not review yellow page ads of individual providers, unless specifically requested to do so.

G. **Member-initiated meetings with MCO staff prior to enrollment:** Face-to-face meetings requested by members are permitted. These meetings may occur at a mutually agreed upon site.

H. **Mailings by the MCO:** MCO mailings shall be permitted in response to member oral or written requests for information. The content of marketing or promotional mailings shall be approved by HSD. MCOs may, with HSD approval, provide potential members with information regarding the MCO/SCI benefit package. MCOs shall not send gifts, however nominal in value, in these mailings. MCOs may send solicited and unsolicited mailings to members and potential members. Unsolicited mailings are defined as: newsletters; notification of outreach events and member services meetings; educational materials and literature related to the MCO preventive medicine initiatives, (such as, diabetes screening, drug and alcohol awareness, and mammograms). HSD shall approve the content of mailings except health education materials. The target audience of the mailings shall be approved by HSD.

I. **Group meetings:** The MCO may hold public meetings. HSD shall be furnished with notice of the meetings and shall prior approve marketing material to be presented at the meeting. HSD shall approve the methodology used by the MCO to solicit attendance for the public meetings. HSD may attend the meeting.

J. **Light refreshments for members at meetings:** The MCO may offer light refreshments at approved group meetings. The availability of food and beverages shall not be mentioned in advertisements for the meetings. *Alcoholic beverages shall not be offered at meetings.*

K. **Gifts, cash incentives or rebates to potential members:** MCOs and their providers, with HSD approval, may disseminate marketing materials, including nominal gifts such as pens, key chains and magnets to potential members.

L. **Gifts to members at health milestones unrelated to enrollment:** Members may be given "rewards" for accessing care, such as a baby T-shirt when a woman completes a targeted series of prenatal visits. Items that reinforce a member's healthy behavior, (car seats, infant formula, magnets and telephone labels) that advertise the member services hotline and the PCP office telephone number for members are examples of "rewards". HSD shall approve gifts with a retail value of over $25.00. Health education videos may be provided. HSD encourages MCOs to include reward items in information sent to new MCO members.

M. **Marketing time frames:** The MCO may initiate marketing and outreach activities at any time.

[8.306.5.14 NMAC - N, 7-1-05; A/E, 8-1-07; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 6 PROVIDER NETWORKS

8.306.6.9 GENERAL NETWORK REQUIREMENTS: The MCO shall establish and maintain a comprehensive network of providers willing and capable of serving members enrolled with the MCO.

A. **Service coverage:** The MCO shall provide or arrange for the provision of services described in 8.306.7 NMAC, *Benefit Package* prior to contract start date. The MCO is solely responsible for the provision of covered services and shall ensure that its network includes providers in sufficient numbers and required specialists to make all services included in the package available and in accordance with access standards as specified herein and in 8.305.8.18, *Medicaid Managed Care Quality Management Standards for Access*.

B. **Comprehensive network:** The MCO shall contract with the full array of providers necessary to deliver a level of care at least equal to, or better than, community norms. The MCO shall contractually require that all network providers and subcontractors be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). In establishing and maintaining the network of appropriate providers, the MCO shall consider the following:

(1) the numbers of network providers who are not accepting new SCI members, as identified by a process for checking the open/closed panel status;

(2) the geographic location of providers and SCI members, considering distance, travel time, the means of transportation ordinarily used by SCI members; and

(3) whether the location provides physical access for SCI members, including members with disabilities.

C. **Maintenance of provider network:** The MCO shall notify HSD within five working days of unexpected changes to the composition of its provider network that negatively affects members' access or the MCO's ability to deliver services included in the benefit package in a timely manner. The MCO shall regularly update open and closed panel status and post this information on its website. Anticipated material changes in an MCO provider network shall be reported to HSD in writing when the MCO knows of the anticipated change or within 30 calendar days, whichever comes first. A notice of significant change shall contain:

(1) the nature of the change;

(2) how the change effects delivery of or access to covered services; and

(3) the MCO's plan for maintaining access and the quality of member care.

D. **Required policies and procedures:** The MCO shall maintain policies and procedures on provider recruitment and termination of provider participation with the MCO. The recruitment policies and procedures shall describe how an MCO responds to a change in the network that affects access and its ability to deliver services in a timely manner. The MCO:

(1) shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;

(2) shall not discriminate against providers with respect to participation, reimbursement, or indemnification for any provider acting within the scope of that provider's license or certification under applicable state law solely on the basis of the provider's license or certification;

(3) shall not decline to include individual or groups of providers in its network without giving the affected providers written notice of the reason for its decision;

(4) shall not be required to contract with providers beyond the number necessary to meet the needs of its members;

(5) shall be allowed to use different reimbursement amounts for different specialties or for different practitioners within the same specialty;

(6) shall be allowed to establish measures that are designed to maintain quality of services and control costs and are consistent with its responsibility to members;

(7) may not employ or contract with providers excluded from participation in federal health care programs because of misconduct; and

(8) shall not be required to contract with providers who are ineligible to receive reimbursement under medicaid fee-for-service.

E. **General information submitted to HSD:** The MCO shall maintain an accurate list of contracted, subcontracted, pending and terminated PCPs, specialists, hospitals and other providers participating or affiliated with the MCO. The MCO shall submit the list to HSD on a monthly basis and include a clear delineation of all additions and terminations that have occurred since the last submission.

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

8.306.6.12 PRIMARY CARE PROVIDERS: The primary care provider (PCP) shall be a participating MCO medical provider who has the responsibility for supervising, coordinating and providing primary health care to members, initiating referrals for specialist care and maintaining the continuity of the member's care. The MCO shall distribute information to the providers explaining the SCI-specific policies and procedures outlining PCP responsibilities.

A. **Primary care responsibilities:** The MCO shall ensure that the following primary care responsibilities are met by the PCP or in another manner:

(1) 24-hour, seven day a week access to care;

(2) coordination and continuity of care with providers who participate within the MCO network and with providers outside the MCO network according to MCO policy;

(3) maintenance of a current medical record for the member, including documentation of services provided to the member by the PCP and specialty or referral services;

(4) requiring PCPs contracted with the MCO to vaccinate members in their offices and not refer members elsewhere for immunizations;

(5) ensuring the member receives appropriate prevention services for his age group;

(6) following MCO established procedures for coordination of services for members with providers participating in the MCO network; and

(7) the MCO shall develop and implement policies and procedures governing how coordination with the PCP will occur with hospitals that require in-house staff to examine or treat members having outpatient or ambulatory surgical procedures performed.

B. **Types of primary care providers:** The MCO may designate the following providers as PCPs, as appropriate:

(1) medical doctors or doctors of osteopathic medicine with the following specialties: general practice, family practice, internal medicine, gerontology, obstetrics, and gynecology;

(2) certified nurse practitioners, certified nurse midwives and physician assistants;

(3) specialists, on an individualized basis for members whose care is more appropriately managed by a specialist, such as members with infectious diseases, chronic illness or a disability;

(4) primary care teams consisting of residents and a supervising faculty physician for contracts with teaching facilities or teams that includes certified mid-level practitioners who, at the member’s request, may serve as the point of first contact; in both instances, the MCO shall organize its teams to ensure continuity of care to members and shall identify a “lead physician” within the team for each member; the “lead physician” shall be an attending physician (medical students, interns and residents cannot serve as the “lead physician”); or

(5) other providers who meet the MCO credentialing requirements as a PCP.

C. **Providers that shall not be excluded as PCPs:** MCOs shall not exclude providers as primary care providers based on the proportion of high-risk patients in their caseloads.

D. **Selection or assignment to a PCP:** The MCO shall maintain written policies and procedures governing the process of member selection of a PCP and requests for a change in PCP.

(1) **Initial enrollment:** At the time of enrollment into the MCO, the MCO shall ensure that each member may choose a PCP within a reasonable distance from the member’s residence.

(a) The MCO shall assume responsibility for assisting members with PCP selection.

(b) The process whereby the MCO assigns members to PCPs shall include at least the following features:

(i) the MCO shall contact the member within five business days of enrollment and provide information on options for selecting a PCP;

(ii) the MCO shall offer freedom of choice to members in making a selection;

(iii) a member shall choose a PCP or the MCO will assign a PCP within 15 calendar days of enrollment with the MCO; a member may select a PCP from the information provided by the MCO; a member may choose a PCP anytime during this selection period;

(iv) the MCO shall notify the member in writing of his PCP’s name, location and office telephone number; and

(v) the MCO shall provide the member with an opportunity to select a different PCP if he is dissatisfied with assigned PCP.

(2) **Subsequent change in PCP initiated by member:** Members may initiate a PCP change at any time, for any reason. The request for PCP change may be made in writing or by telephone. If the change is

requested by the 20th day of the month it will become effective the first day of the following month. If the request is made after the 20th day it will become effective the first day of the second month following the request.

(3) **Subsequent change in PCP initiated by the MCO:** In instances where a PCP has been terminated or suspended for potential quality or fraud and abuse issues, the MCO shall allow affected members to select another PCP or make an assignment within 15 days of the termination effective date. The MCO shall notify the member in writing of the PCP's name, location and office telephone number. The MCO may initiate a PCP change for a member under certain circumstances such as:

(a) the member and MCO agree that assignment to a different PCP in the MCO is in the member's best interest, based on the member's medical condition;

(b) a member's PCP ceases to participate in the MCO's network;

(c) a member's behavior toward the PCP is such that it is not feasible to safely or prudently provide medical care and the PCP has made all reasonable efforts to accommodate the member; or

(d) a member has initiated legal action against the PCP.

(4) **Provider lock-in:** HSD shall allow the MCO to require that a member see a certain provider while ensuring reasonable access to quality services when identification of utilization of unnecessary services or a member's behavior is detrimental or indicates a need to provide case continuity. Prior to placing a member on provider lock-in, the MCO shall inform the member of the intent to lock-in, including the reasons for imposing the provider lock-in and that the restriction does not apply to emergency services furnished to the member. The MCO's grievance procedure shall be made available to a member disagreeing with the provider lock-in. The member shall be removed from provider lock-in when the MCO has determined that the utilization problems or detrimental behavior have ceased and that recurrence of the problems is judged to be improbable. HSD shall be notified of provider lock-ins on a quarterly basis and informed of provider lock-in removals at the time they occur.

(5) Pharmacy lock-in: HSD shall allow the MCO to require that a member see a certain pharmacy provider when member compliance or drug seeking behavior is suspected. Prior to placing the member on pharmacy lock-in, the MCO shall inform the member or his/her representative of the intent to lock-in. The MCO's grievance procedure shall be made available to the member being designated for pharmacy lock-in. The pharmacy lock-in shall be reviewed and documented by the MCO and reported to HSD every quarter. The member shall be removed from pharmacy lock-in when the MCO has determined that the compliance or drug seeking behavior has been resolved and the recurrence of the problem is judged to be improbable. HSD shall be notified of all lock-in removals.

E. **MCO responsibility for PCP services:** The MCO shall be responsible for monitoring PCP actions to ensure compliance with MCO and HSD policies. The MCO shall ensure that PCPs are successfully identifying and referring members to specialty providers as medically necessary.

[8.306.6.12 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 7 BENEFIT PACKAGE

8.306.7.11 SERVICES INCLUDED IN THE SCI BENEFIT PACKAGE: The SCI benefit package includes provider and consultation services and supplies that are reasonably required to maintain good health and are provided by or under the direction of the member's PCP. The following lists covered services and provides additional information.

A. **Provider services**:

(1) office visits;
(2) home visits;
(3) hospital and inpatient physical rehabilitation facility visits by physician;
(4) inpatient and outpatient surgery (includes assistant surgeon's charges);
(5) office procedures;
(6) inpatient professional care services, including pathologists, radiologists and anesthesiologists;
(7) allergy testing;
(8) allergy injections;
(9) antigen serum;
(10) injections in accordance with accepted medical practice to treat acute conditions, which are customarily administered in a provider's office;
(11) injections in accordance with acceptable medical practice used to treat chronic conditions, including, but not limited to, diseases such as rheumatoid arthritis, crohn's disease, and hepatitis C; and
(12) routine and diagnostic x-rays and clinical laboratory tests.

B. **Inpatient hospital services:** The benefit package includes inpatient hospital services as detailed below.

(1) Hospital admissions must have prior authorization and are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP. Any service or procedure not outlined below requires a prior authorization.
(2) Inpatient hospitalization coverage is limited to [~~twenty-five (25)~~] 25 days per benefit year. This [~~twenty-five (25)~~] 25-day limitation is combined with home health services and inpatient physical rehabilitation.
(3) Inpatient hospital services include:
(a) semi-private room and board accommodations, including general duty nursing care;
(b) private room and board accommodations when medically necessary; prior authorization is required;
(c) in-hospital therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units;
(d) use of all hospital facilities, including operating, delivery, recovery, and treatment rooms and equipment;
(e) laboratory tests, x-rays, electrocardiograms (EKGs), electroencephalograms (EEGs), and other diagnostic tests performed in conjunction with a member's admission to a hospital;
(f) anesthetics, oxygen, pharmaceuticals, medications, and other biological;
(g) dressings, casts, and special equipment when supplied by the hospital for use in the hospital;
(h) inpatient meals and special diets;
(i) inpatient radiation therapy [~~and/or~~] or inhalation therapy;
(j) rehabilitative services - physical, occupational, and speech therapy;
(k) administration of whole blood, blood plasma, and components;
(l) discharge planning and coordination of services; and
(m) maternity care.

C. **Outpatient services:** The benefit package includes outpatient services performed in a hospital or other approved outpatient facility. Outpatient services:

(1) can reasonably be provided on an ambulatory basis;
(2) are preventive, diagnostic or treatment procedures provided under the direction of the member's PCP or a consulting provider to whom the member is referred by the PCP;
(3) require prior authorization, unless otherwise noted; and

(4) the following provides additional information on covered outpatient services and associated co-payments:

(a) surgeries, including use of operating, delivery, recovery, treatment rooms, equipment and supplies, including anesthesia, dressings and medications;

(b) radiation therapy and chemotherapy;

(c) magnetic resonance imaging (MRI);

(d) positron emission tomography (PET) tests;

(e) CT scan;

(f) holter monitors and cardiac event monitors;

(g) routine and diagnostic x-rays, clinical laboratory tests, electrocardiograms (EKGs), and electroencephalograms (EEGs);

(h) cardiovascular rehabilitation; and

(i) rehabilitative services - physical, occupational, and speech therapy; rehabilitative services for short-term physical, occupational, and speech therapies are covered; short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment; the member's PCP or other appropriate treating provider to whom the member has been referred shall determine in advance of rehabilitative services that these services can be expected to result in significant improvement in the member's physical condition within a period of two months; requests for rehabilitative services from therapists will not be approved; these services shall be requested by the ordering provider and require a prior authorization.

(i) Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, contingent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the member's physical condition within the extension period. Expectation of significant improvement will be established if the member has complied fully with the instructions for care and has met all therapy goals for the preceding two-month period as documented in the therapy record.

(ii) Therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered under SCI. Long-term therapy includes treatment for chronic or incurable conditions for which rehabilitative services produce minimal or temporary change or relief. Chronic conditions include, but are not limited to, muscular dystrophy, cerebral palsy, developmental delay, myofascial pain disorders, arthritis, autism, and syndromes of chromosomal abnormalities.

D. **Emergency and urgently needed health services:** The benefit package includes emergency and urgently needed health services. These services are available [~~twenty-four (24)~~] 24 hours a day, seven [~~(7)~~] days a week. The benefit package includes inpatient and outpatient services meeting the definition of emergency services, which shall be provided without regard to prior authorization or the provider's contractual relationship with the MCO. If the services are needed immediately and the time necessary to transport the member to a network provider would mean risk of permanent damage to the member's health, emergency services shall be available through a facility or provider participating in the MCO/SE network or from a facility or provider not participating in the MCO/SE network. Either provider type shall be paid for the provision of services on a timely basis. Emergency services include services needed to evaluate and stabilize an emergency medical or behavioral condition. Post stabilization care services means covered services, related to an emergency medical or behavioral condition, that are provided after a member is stabilized in order to maintain the stabilized condition. This coverage may include improving or resolving the member's condition if either the MCO has authorized post-stabilization services in the facility in question, or there has been no authorization; and

(1) the hospital was unable to contact the MCO; or

(2) the hospital contacted the MCO but did not get instructions within an hour of the request; the following provides additional information on covered services and required co-payments.

(a) Emergency health services can be provided in or out of the service area. Coverage is provided for trauma services at an appropriately designated trauma center according to established emergency medical services triage and transportation protocols.

(i) Prior authorization is not required for emergency care.

(ii) Coverage for trauma services and all other emergency health services from non-participating providers will continue at least until the member is medically stable, does not require critical care, and can be safely transferred to another facility based on the judgment of the attending participating provider in consultation with the MCO. The MCO may transfer hospitalized members to the care of participating providers as

soon as it is medically appropriate. Such members shall be stabilized and the transfer effected in accordance with federal law.

(iii) The member is responsible for charges for non-covered services.

(b) Use of an urgent care center, where available, in or out of the service area for treatment of sudden unexpected acute illness or injury that requires prompt medical attention to prevent jeopardy to the member if such services were not received immediately.

(i) A non-participating urgent care center may be used only if the member cannot reasonably access a participating provider.

(ii) Routine or follow-up medical treatment shall be provided by or through a participating provider.

E. **Women's health services:** The benefit package includes any gynecological examinations or care related to pregnancy, for primary and preventive obstetrics, and gynecological services required as a result of any gynecological examination or condition. Covered women's health services may be obtained from the member's PCP, or a participating women's health care provider or a consulting provider to whom the member has been referred by her PCP. The following lists covered services and provides additional information:

(1) office visits;

(2) low-dose mammography screening for detection of breast cancer;

(3) cytological screening to determine the presence of pre-cancerous or cancerous conditions or other health problems; and

(4) services related to the diagnosis, treatment and appropriate management of osteoporosis.

F. **Prenatal and post-partum care:** Prenatal care includes a minimum of one prenatal office visit per month during the first two trimesters of pregnancy; two [~~(2)~~] office visits per month during the seventh and eight months of pregnancy; and one [~~(1)~~] office visit per week during the ninth month until tremor as medically indicated, provided that coverage for each office visit shall include prenatal counseling and education.

(1) Following delivery of a newborn, a female member is entitled to either:

(a) post-partum care in the home consisting of up to three visits; or

(b) a minimum hospital stay of specified inpatient hours; the choice of either home care or inpatient care will be made based on discussion between the participating provider and the member.

(2) If post-partum home care is elected, the care shall be rendered in accordance with accepted maternal and neonatal physician assessments, and by a home care participating provider who is properly licensed, trained and experienced. A maximum of three home care visits are allowable.

(3) If inpatient care is elected, a mother and her newborn child in a health care facility will be entitled to a minimum stay of 48 hours following a vaginal delivery or 96 hours following a caesarian section.

(4) Non- hospital births - prior authorization is required.

G. **Preventive health services:** The benefit package includes preventive health services. Preventive health services are provided to a member when performed by or under the direction of the member's PCP or a participating provider to whom the member has been referred by his PCP, and are consistent with the MCO'S preventive health guidelines. The following lists covered services and provides additional information.

(1) Physical exams, including health appraisal exams, laboratory and radiological tests, hearing and vision screenings, and early detection procedures.

(2) Periodic tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or a fractionated cholesterol level.

(3) Periodic glaucoma eye tests for all persons [~~thirty-five (35)~~] 35 years of age and older.

(4) Periodic stool examination for the presence of blood for all persons 40 years of age or older.

(5) Periodic mammograms for detection of breast cancer as follows: one low dose baseline mammogram for women ages 35 through 39, one low dose mammogram biennially for women ages 40 through 49 and one low dose mammogram annually for women over age 50.

(6) All members may receive an annual consultation to discuss lifestyle behaviors that promote health and well-being. The consultation may include, but not be limited to:

(a) smoking control;

(b) nutrition and diet recommendations;

(c) exercise plans;

(d) lower back protection;

(e) immunization practices;

(f) breast self-examinations;

(g) testicular self-examinations; or

(h) use of seat belts in motor vehicles.

(7) Adult immunizations in accordance with the recommendations of the advisory committee on immunization practices (ACIP).

(8) Periodic colon examination of [~~thirty-five (35) to sixty (60)~~] 35 to 60 centimeters [~~and/or~~] or barium enema for all persons [~~forty-five (45)~~] 45 years of age or older.

(9) Voluntary family planning services.

(10) Insertion of contraceptive devices.

(11) Removal of contraceptive devices.

(12) Surgical sterilization.

(13) Pregnancy termination procedures: The benefit package includes services for the termination of pregnancy and pre or post-decision counseling or psychological services as detailed in 8.325.7 NMAC, *Pregnancy Termination Procedures.*

H. **Dialysis:** The benefit package includes dialysis services. Long-term hemodialysis and continuous ambulatory peritoneal dialysis (CAPD) is provided with a prior authorization and performed by or under the direction of the member's PCP or a consulting provider to whom the member has been referred by his PCP. The member shall advise the MCO of the date the treatment commenced.

I. **Inpatient physical rehabilitation:** The benefit package includes inpatient physical rehabilitation. The following lists covered services and provides additional information.

(1) Inpatient physical rehabilitation services require prior authorization, and services are to be provided under the direction of the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Inpatient physical rehabilitation facility coverage is limited to [~~twenty-five (25)~~] 25 days per benefit year. This [~~twenty-five (25)~~] 25-day limitation is combined with inpatient hospital and home health services.

J. **Home health services/home intravenous services:** The benefit package includes home health services, which are health services provided to a member confined to his home due to physical illness. The following lists covered services and provides additional information.

(1) Home health services and home intravenous services are provided by a home health agency (HHA) at a member's home with a prior authorization and prescribed by the member's PCP or a consulting provider to whom the member is referred by his PCP.

(2) Home health services in lieu of hospitalization are limited to [~~twenty-five (25)~~] 25 days per benefit year provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. This [~~twenty-five (25)~~] 25 day limitation is combined with inpatient hospitalization and inpatient physical rehabilitation.

(3) Services provided by a registered nurse or a licensed practical nurse; by physical, occupational, and respiratory therapists; speech pathologists; or by a home health aide are covered.

(4) Prescription supplies for the provision of home health services at the time of a home health visit are covered.

(5) Home intravenous services are covered.

(6) Tube feedings as the sole source of nutrition are covered.

K. **Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices:** The benefit package includes durable medical equipment, medical supplies, orthotic appliances, and prosthetic devices. The following lists covered services and provides additional information.

(1) Prior authorization is required.

(2) Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices with allowable charges of $200 or more per item, including tax and any shipping charges are covered. Rental price cannot exceed purchase price.

(3) Durable medical equipment that requires a provider's prescription for purchase or rental is covered unless otherwise excluded.

(4) Medical supplies that require a provider's prescription for purchase are covered unless otherwise excluded.

(5) Orthotic appliances that require a provider's prescription for purchase are covered unless otherwise excluded.

(6) Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal [~~and/or~~] or when the body's growth or atrophy necessitates replacement, unless otherwise excluded.

(7) Breast prostheses and bras required in conjunction with reconstructive surgery are covered, except as limited.

(8) Repair or replacement of durable medical equipment, orthotic appliances and prosthetic devices due to normal wear [~~and/or~~] or when necessitated by the body's growth or atrophy are covered.

L. **Ambulance services:** The benefit package includes emergency transport services identified below.

(1) When necessary to protect the life of the mother or infant, emergency transport includes transport for medically high-risk pregnant women with an impending delivery to the nearest tertiary care facility.

(2) The MCO will not pay more for air ambulance than it would have paid for transportation over the same distance by surface emergency medical transportation services unless the member's health condition renders the utilization of such surface services medically inappropriate.

(3) Emergency ground ambulance transportation to the nearest facility where emergency care and treatment can be rendered and when provided by a licensed ambulance service

(4) Emergency, trauma-related air ambulance transportation - prior authorization is required, when feasible.

M. **Oral surgery:** The benefit package includes limited oral surgery benefits with prior authorization. The following lists covered services and provides additional information. General dental and oral surgery services with a prior authorization only in conjunction with:

(1) Accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within [~~seventy-two (72)~~] 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within [~~twelve (12)~~] 12 months of the date of injury. The MCO will require dental x-rays.

(2) Surgical procedures to correct non-dental, non-maxillomandibular physiologic conditions that produce demonstrable impairment of function are covered.

(3) Removal or biopsy, when pathological examination is required of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth are covered.

(4) External incision and drainage of cellulitis; incision of infected accessory sinuses, salivary glands or ducts; and removal of stones from salivary ducts are covered.

(5) Surgical procedures to correct accidental injuries of the jaws and facial bones, cheeks, lips, tongue, roof and floor of mouth are covered.

N. **Reconstructive surgery:** The benefit package includes reconstructive surgery as provided below.

(1) Reconstructive surgery from which an improvement in physiological function can be expected if performed for the correction of functional disorders - prior authorization is required. Functional disorder shall result from accidental injury or from congenital defects or disease.

(2) Prosthetic devices and reconstruction surgery of the affected breast or other breast to produce symmetry related to mastectomy. This coverage includes physical complications at all stages of mastectomy, including lymph edemas. A member is allowed at least [~~forty-eight (48)~~] 48 hours of inpatient care following mastectomy and [~~twenty-four (24)~~] 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

O. **Prescription drugs:** The benefit package includes all generic prescription drugs and brand name drugs included on the MCO'S preferred drug list (PDL). Exceptions to the PDL depend on MCO policy.

P. **Diabetes treatment:** The benefit package includes diabetes treatment. The MCO will maintain an adequate PDL to provide resources to members with diabetes; and guarantee reimbursement or coverage for prescription drugs, insulin, supplies, equipment and appliances with a prior authorization described in this subsection within the limits of the MCO. The following lists covered services and provides additional information.

(1) Equipment, supplies and appliances to treat diabetes to include:

(a) blood glucose monitors, including those for the legally blind;
(b) test strips for blood glucose monitors;
(c) visual reading urine and ketone strips;
(d) lancets and lancet devices;
(e) insulin (limit two [~~(2)~~] vials per co-payment);
(f) injection aids, including those adaptable to meet the needs of the legally blind;
(g) syringes;
(h) prescriptive oral agents for controlling blood sugar levels;

(i) medically necessary podiatric appliances for prevention of foot complications associated with diabetes, including therapeutic molded or depth inlay shoes, functional orthotic appliances, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment; and

(j) glucagons emergency kits.

(2) Diabetes self-management training by a certified, registered or licensed health care professional with recent education in diabetes management, which is limited to:

(a) medically necessary visits upon the diagnosis of diabetes;

(b) visits following a provider diagnosis that represents a significant change in the member's symptoms or condition that warrants changes in the member's self-management;

(c) visits when re-education or refresher training is prescribed by a health care provider with prescribing authority; and

(d) medical nutrition therapy related to diabetes management.

Q. **Behavioral health and substance abuse services:** The benefit package includes behavioral health and substance abuse services. Inpatient behavioral health services are limited to [~~twenty-five (25)~~] 25 days per benefit year with prior authorization.

(1) **Behavioral health service:**

(a) Outpatient office visits for mental health evaluation and treatment; injectable forms of haloperidol or fluphenazine are included in the office visit co-payment. Prior authorization is required for over seven (7) visits.

(b) Inpatient mental health services provided in a psychiatric hospital or an acute care general hospital - *prior authorization is required*.

(2) **Substance abuse service:**

(a) outpatient substance abuse including visits, detoxification and intensive outpatient care limited to forty two (42) days per benefit year; and

(b) inpatient substance abuse detoxification - *prior authorization is required.*

R. **Annual limits on out-of-pocket expenditures:** Out-of-pocket charges for all participants will be limited to 5 percent of maximum gross [~~family~~] household income per benefit year. Pharmacy out-of-pocket charges for all participants will be limited to $12 per month.

S. **Limitations on coverage:** The benefit package is limited to $100,000 in benefits payable per member per benefit year.

T. **Pregnancy termination procedures:** The MCO shall provide coverage of pregnancy termination as allowed per 42 CFR 457.475. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 457.475 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.325.7 NMAC.

[8.306.7.11 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

8.306.7.12 COVERED SERVICES AND SERVICE LIMITATIONS: The SCI benefit package is limited to $100,000 in benefits payable per member per benefit year. Covered services are subject to the following conditions and limitations:

A. **Medically necessary:** Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

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

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

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

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

B. Behavioral health and substance abuse services:

(1) Inpatient mental health services/partial hospitalizations are limited to [~~twenty-five (25)~~] 25 days per benefit year.

(2) Inpatient substance abuse detoxification is limited to 72 hours per occurrence as part of the total twenty-five day benefit for inpatient mental health services.

(3) Outpatient substance abuse detoxification services are limited to ten [~~(10)~~] days per benefit year. Substance abuse outpatient services including intensive outpatient services are limited to [~~forty-two (42)~~] 42 days per benefit year.

C. **Cardiovascular rehabilitation:** Coverage for cardiovascular rehabilitation is limited to a maximum of [~~thirty-six (36)~~] 36 sessions per cardiac event.

D. **Choice of provider:** For the purpose of coverage under this policy, the SCI MCO has the right to determine which provider may be used to provide the covered services.

E. **Contact lenses or eyeglasses following cataract surgery:** One complete set of contact lenses or eyeglasses is covered following surgery for the removal of cataracts from one or both eyes. Coverage is not allowed for both contact lenses and eyeglasses. Coverage is limited to one set of contact lenses or eyeglasses per member per surgery. Coverage for materials (contact lenses or eyeglasses) is limited to $300 per surgery. Coverage for contact lenses or eyeglasses is limited to [~~ninety (90)~~] 90 days following surgery for the removal of cataracts. Contact lenses or eyeglasses obtained after the [~~ninety (90)~~] 90 day period are not covered.

F. **Dental services:** In cases of accidental injury to sound natural teeth, the jawbones, or surrounding tissues, treatment for injury is covered when initial treatment for the injury is sought within [~~seventy-two (72)~~] 72 hours of the injury. Teeth with crowns or restorations are not considered to be sound natural teeth. The injury shall be properly documented during the initial treatment. Services shall be completed within [~~twelve (12)~~] 12 months of the date of injury. The MCO will require dental x-rays.

G. **Detoxification:** Inpatient detoxification is limited to seventy-two (72) hours of inpatient services per occurrence as part of the twenty-five day benefit for inpatient behavioral health services. Outpatient detoxification is limited to ten [~~(10)~~] days per benefit year.

H. **Home health services:** Home health services in lieu of hospitalization, or a combination of inpatient hospitalization, home health services and inpatient rehabilitation, may not exceed [~~twenty-five (25)~~] 25 days per benefit year, provided that a period of inpatient hospitalization coverage shall precede any home health care coverage or the PCP shall provide a statement indicating that inpatient hospitalization would be necessary in the absence of home health services. Home health services are subject to periodic review of the continuation of covered services. If home health services can be provided in more than one medically appropriate setting, the MCO may choose the setting for providing the care.

I. **Inpatient hospitalization, home health services, inpatient rehabilitation:** This policy is limited to maximum of [~~twenty-five (25)~~] 25 combined days per member per benefit year for inpatient hospitalization, home health services and inpatient rehabilitation.

J. **Major disasters:** In the event of any major disaster, epidemic, or other circumstance beyond its control, the MCO will render or attempt to arrange covered services with participating providers insofar as practical according to its best judgment and within the limitations of facilities, supplies, pharmaceuticals, and personnel available. Such circumstances include: complete or partial disruption of facilities; war; riot; civil uprising; disability of the MCO personnel; disability of participating providers; or act of terrorism.

K. **Maximum benefit limits:** Maximum benefits allowed under SCI are limited to $100,000 per member per benefit year.

L. **Maternity transport:** Coverage for transportation where medically necessary to protect the life of the infant or mother, including air transport if indicated for medically high risk pregnant women with an impending delivery of a potentially viable infant to the nearest available tertiary care center.

M. **Mastectomy and lymph node dissection:** Length of inpatient stay: not less than [~~forty-eight (48)~~] 48 hours inpatient stay following a mastectomy and not less than [~~twenty-four (24)~~] 24 hours of inpatient care following a lymph node dissection when determined medically appropriate by physician and patient.

N. **Orthotic appliances and prosthetic devices:** Repair or replacement of orthotic appliances and prosthetic devices due to normal wear is covered.

O. **Physical, speech and occupational therapy:** Only short-term rehabilitative services are covered. Short-term therapy is limited to no more than two [~~(2)~~] consecutive months per member per condition.

P. **Post mastectomy supplies:** Bras required in conjunction with reconstructive surgery are limited to two [~~(2)~~] per member, per benefit year.

Q. **Prescription drugs:** Prescription drugs are limited to generic drugs and name brand prescriptions on the preferred drug list (PDL) drugs as listed on the MCO PDL. The MCO shall ensure that Native American members accessing prescription drugs at IHS or Tribal 638 facilities will be exempt from the MCO's PDL. For each co-payment amount, quantities are limited to a [~~thirty (30)~~] 30-day supply or [~~one hundred (100)~~] 100 tablets; whichever is less, per prescription or refill. All other units will be dispensed in a [~~thirty (30)~~] 30 -day supply, with one co-payment required for each of the following quantities:

(1) **Topical products:** The lesser of [~~eighty (80)~~] 80 gm. of cream/ointment or [~~sixty (60)~~] 60 ml. of lotion/solution or the most commonly dispensed trade package size, per co-payment.

(2) **Oral liquids:** 480 ml. maximum per co-payment.

(3) **Inhalers and vials:** One [~~(1)~~] co-payment per unit (diabetic insulin exception - two [~~(2)~~] vials of the same type of insulin per co-payment).

(4) **Manufacturer's trade package:** One [~~(1)~~] co-payment per trade package (i.e. imitrex, estrogen patches).

(5) **Mail order drugs** are limited to drugs available through the MCO'S mail order distributor.

R. **Transplants - organ, bone marrow, [~~and/or~~] or tissue:**

(1) Organ, bone marrow, [~~and/or~~] or tissue transplants are limited to:

(a) heart;

(b) heart/lung;

(c) lung;

(d) liver;

(e) cornea;

(f) kidney;

(g) skin;

(h) bone marrow (allogenic and autologous stem cell rescue only for leukemia, aplastic anemia, severe combined immunodeficiency disease, wiskott-aldrich syndrome, advanced hodgkin's or non-hodgkin's lymphoma, recurrent or refractory neuroblastoma, and multiple myelomas); or

(i) pancreas (for uremic, insulin-dependent diabetics concurrently receiving a kidney transplant).

(2) No other transplant procedures are covered. The MCO has the right to require that transplants be performed at contracted centers of excellence if one is available.

(3) A member is eligible for coverage for up to two [~~(2)~~] transplants per lifetime. Multiple organ, bone marrow, [~~and/or~~] or tissue transplants performed at the same time are considered to be one procedure. All transplant services are limited by the $100,000 annual benefit limitation per member per benefit year.

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

8.306.7.13 SERVICES EXCLUDED FROM THE SCI BENEFIT PACKAGE: SCI does not cover any service or supply not specifically listed in 8.306.7.12 NMAC as a covered service. If a service is not a covered service, then all services performed in conjunction with the non-covered service are not covered as well. The list of exclusions below is not intended to be exhaustive. If a service is not listed in 8.306.7.12 NMAC as a covered service, then it is not covered regardless of medical necessity. Other services excluded are:

A. **Services not coordinated through a member's PCP or lack of a prior authorization:** Health services and supplies if not provided by or under the direction of:

(1) the member's PCP or a provider to whom the member has been referred by his PCP;

(2) a non-participating provider to whom the member has been referred by his PCP, and a prior authorization is in place for those services; or

(3) any services or supplies that require a prior authorization if a prior authorization is not obtained.

B. **Services not medically necessary, not standard medical practice, or experimental:** The following services are not covered:

(1) any treatment, procedure, facility, equipment, drug, drug use, device, or supply that is not medically necessary; SCI pays only for medically necessary services furnished by approved providers to eligible recipients; SCI does not cover experimental or investigational medical, surgical, or other health care procedures or treatments, including the use of drugs, biological products, other products or devices except routine patient costs associated with certain Phase I, II III and IV cancer clinical trials;

(2) drugs and devices that are not FDA approved, not FDA approved for the proposed use, or that have been voluntarily removed from the market; and

(3) medical, surgical, [~~and/or~~] or behavioral health procedures, pharmacological regimes, and/or associated health services if they are experimental, under investigation, or generally not standard medical practice.

C. **Acupuncture and chiropractic services:** Acupuncture and chiropractic services are not covered.

D. **Assistant surgeon services:** Assistant surgeon services are not covered if not approved by the MCO.

E. **Behavioral health:** The following behavioral health services are not covered: behavioral health services that are rendered in connection with disorders not classified in the international classification of diseases, 9th revision, clinical modification (ICD-9-CM). Behavioral health services that are not inpatient hospitalizations or outpatient visits including, but not limited to, residential treatment services, treatment foster care, day treatment, and neurobehavioral programs.

F. **Cosmetic services:** Cosmetic services are not covered, including but not limited to: surgery, services, or procedures to change family characteristics or conditions due to aging; dermabrasion; scar reconstruction or revision; acne surgery (including excision of scarring and cryotherapy); tattoo removal; orthognathic jaw surgery; services performed in connection with the enlargement, reduction, implantation, or change in appearance of a portion of the body; surgical excision or reformation of sagging skin on any part of the body including, but not limited to eyelids, face, neck, abdomen, arms, legs or buttocks; microphlebectomy; sclerotherapy; liposuction; rhinoplasty; otoplasty; services related to a cosmetic service, or required as a result of a noncovered cosmetic service; surgery required as a result of a noncovered procedure (such as a noncovered organ/tissue transplant or a sex change operation) or additional surgery or treatment required to care for or correct a complication due to a previous cosmetic service; or breast augmentation, reduction mammoplasty, or nipple reconstruction except as related to reconstructive surgery.

G. **Court ordered care:** Court-mandated evaluations and treatment that would not be in compliance with the terms and conditions of the MCO contract are not covered.

H. **Coverage out of the service area:** Coverage while away from service area, except for emergency health services and urgently needed health services, is not included unless otherwise covered.

I. **Custodial care:** Custodial or home (domestic) care, including services and supplies that can be performed by non-licensed medical personnel to help a member meet the normal activities of daily living are not covered. Examples of custodial care that are not covered services are:

(1) bathing;
(2) feeding;
(3) preparing meals; and
(4) performing housekeeping tasks.

J. **Dental services:** The following dental services are not covered:

(1) All general dental services and dental x-rays, including but not limited to:
(a) anesthesia and facility services for dental restoration;
(b) removal of impacted teeth;
(c) removal of tori or exostoses;
(d) procedures involving orthodontic care, the teeth, dental implants and periodontal disease;
(e) artificial devices, surgery on the supporting structures of the teeth, and bone grafts to prepare the mouth for denture wear;
(f) personalized restorations, cosmetic replacement of serviceable restorations, or materials that are more expensive than necessary to restore damaged teeth; or
(g) surgical realignment of the jaw structures for functional malocclusion.
(2) Orthodontics, endodontics, and dental prosthetics.
(3) Orthotic and orthodontic appliances and/or treatment, crowns, bridges, and/or dentures used for the treatment of craniomandibular and temporomandibular joint disorders.

K. **Donor services:** Medical and hospital services of a donor when the recipient of an organ, bone marrow, and/or tissue transplant is not a member, or when the transplant procedure is not a covered service are not included in the benefit package.

L. **Durable medical equipment, medical supplies; prosthetic devices; orthotic appliances:** The following are not included in the benefit package:

(1) **Durable medical equipment, medical supplies:**
(a) equipment that is non-medical in nature such as voice synthesizers or other communication devices, waterbeds, jacuzzi units, hot tubs, whirlpools, swimming pools, exercise equipment, heating pads, or hot water bottles;
(b) air conditioners, humidifiers, purifiers, or self-help devices, biofeedback equipment, and tens units;
(c) deluxe equipment, such as motor-driven wheelchairs, chairlifts, or beds, when standard equipment is available and adequate to meet functional requirements;
(d) repairs to equipment that is not owned by the member, or repairs to equipment that exceeds the rental price of another unit for the estimated period of need or that exceeds the purchase price of a new unit;
(e) comfort or safety items such as bed boards, hospital beds or mattresses, flotation mattresses, bathtub lifts, grab bars, over bed tables, adjustable beds, telephone arms, diapers, under pads;
(f) sphygmomanometers, stethoscopes, and blood pressure monitors; or
(g) medical supplies and equipment that can be purchased over the counter such as shower chairs, elevated toilet seats, alcohol pads, and dressing supplies.

(2) **Prosthetic devices:**

(a) prosthetic devices unless they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth or atrophy necessitates replacement;

(b) external prosthetic devices that are suited for heavier physical activity such as fast walking, jogging, bicycling, or skiing;

(c) cosmetic coverings for external prosthetic devices;

(d) repairs of prosthetic devices that are not owned by the member; or

(e) cochlear implants.

(3) **Orthotic appliances:**

(a) accommodative orthotic appliances; orthopedic shoes and shoe orthotic appliances (except when the shoes are attached and an integral part of the brace), arch supports, shoe inserts, special-ordered shoes, custom shoes, built up shoes of any type, and other supportive devices for the feet, except for the management of diabetes as required by law;

(b) orthopedic appliances that can be purchased over-the-counter;

(c) cranial banding services; or

(d) penile prosthesis.

M. **Eyeglasses and vision services:** The following eyeglasses and vision services are not included in the benefit package:

(1) eye refractions, eyeglasses, and contact lenses, [~~and/or~~] or the fitting thereof, and routine vision services, except for contact lenses or eyeglasses following cataract surgery; and

(2) surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses, except for intraocular lenses in connection with cataract removal.

N. **Genetic testing:** Genetic testing, screening (other than by triple serum test only) and counseling, with the exception of genetic testing for the diagnosis or treatment of a current illness are not included in the benefit package.

O. **Health clubs:** Fees for health clubs, spas and exercise programs are not included in the benefit package.

P. **Hearing aids:** The purchase of hearing aids, and/or the fitting thereof, associated hearing aid testing, and other artificial aids, is not included except as specifically defined in Subsection G of 8.306.7.11 NMAC, *Preventive Health Services*.

Q. **Hospice care:** Hospice care is not included in the benefit package.

R. **Illegal acts or crimes:** The following is not covered: Injury or illness sustained during the voluntary participation in a riot or the commission of an illegal act or crime, or while under the influence of alcohol or other drug or controlled substance, which is not prescribed by a provider. For purposes of this Subsection, a person will be presumed to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the MCO. The limitations of this subsection will not apply unless there is a direct causal relationship between the activity described above and the illness or injuries sustained.

S. **Infertility treatment:** Infertility treatment services are not covered.

T. **Learning disorders:** Special education, counseling, therapy, diagnostic testing, or treatment for learning disorders, whether or not associated with a mental disorder, retardation, or other disturbance, are not included in the benefit package.

U. **Marital therapy or counseling:** Marital therapy or counseling is not covered.

V. **Missed appointments:** Costs incurred in conjunction with missed appointments are not included in the benefit package.

W. **Modifications, improvements, equipment:** Home, workplace, and automobile modifications, improvements, or equipment are not included in the benefit package.

X. **No legal obligation to pay:** The following are not included in the benefit package:

(1) services a member is eligible to receive and has received under any governmental program which, in the absence of any health services or insurance plan, no charge would be made to the member; and

(2) services or supplies for which the member has no legal obligation to pay or for which no charge would be made if the member were not eligible for SCI.

Y. **Paternity tests:** Diagnostic tests to establish paternity of a child or unborn child are not included in the benefit package.

Z. **Physical examinations:** The following physical examinations are not included in the benefit package:

(1) routine physical examinations, vaccinations, and/or immunizations if given for:
(a) the purpose of obtaining employment, insurance, passports, or travel; or
(b) for the purpose of medical research.
(2) sports and school physicals, unless done in conjunction with periodic health assessments.

AA. **Physical, speech, occupational therapy - long term:** All long-term physical, speech and occupational therapy services are not included in the benefit package.

BB. **Physical, speech, occupational therapies:** Physical, speech, occupational therapies for the following conditions are not covered:
(1) psychosocial speech delay including delayed language development and developmental apraxia;
(2) mental retardation, down's syndrome, autism, autism spectrum disorders, or dyslexia;
(3) syndromes associates with diagnosed disorders attributed to perceptual and conceptual dysfunctions;
(4) learning disabilities, developmental articulation and language disorders, and stuttering; and
(5) sensory disorders (oral and tactile aversions).

CC. **Podiatry and foot care:** The benefit package does not include podiatry or foot care, including but not limited to: bunion treatment, callus treatment, corn paring or excision, toenail trimming, except in the treatment of insulin-dependent diabetics. Foot massage of any type, treatment of fallen arches, flat or pronated feet, and shock wave treatment are not included in the benefit package.

DD. **Prenatal, delivery, post-partum services:**
(1) **All services related to the prenatal period:** Delivery and post-partum services shall be received in the MCO service area with the exception of a pregnant woman in the third trimester of pregnancy who has an established relationship with an obstetrical provider and desires to continue that relationship, and the provider is not participating with the MCO.
(2) Tests to determine the gender of an unborn child are excluded from coverage.

EE. **Prescription drugs:** The following are excluded from coverage:
(1) brand name non-PDL prescription drugs without prior approval;
(2) drugs that do not require a physician's prescription; except insulin;
(3) contraceptive jellies, creams, foams, devices or implants (except legend contraceptive devices);
(4) therapeutic devices or appliances;
(5) drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or for cosmetic purposes only (e.g., Renova®);
(6) biologicals, blood or blood plasma products;
(7) drugs labeled "caution - limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
(8) medication for which the cost is recoverable under any workers' compensation or occupational disease law or from any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member;
(9) medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution, which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
(10) any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order; and
(11) charges for the administration or injection of any drug.

FF. **Pulmonary rehabilitation:** Pulmonary rehabilitation is not included in the benefit package.

GG. **Recovery:** Services and supplies that are otherwise covered, to the extent that a member realizes a recovery from any source, are not included in the benefit package.

HH. **Repair or replacement for lost, stolen, or damaged items:** Repair or replacement for lost, stolen, or damaged items listed below are not included in the benefit package:
(1) durable medical equipment;
(2) medical supplies;
(3) orthotic appliances;
(4) prosthetic devices; and
(5) prescription drugs.

II. **Services, supplies for excluded services:** Services, supplies, or drugs used for non-covered or excluded procedures or treatment, or used for any related complication(s) are not included in the benefit package.

JJ. **Services, supplies not primarily medical:** Services, supplies, and self-help items that are not primarily medical in nature, for personal comfort or safety, convenience or beautification during an inpatient stay, or in the home setting are not covered. Examples include but are not limited to: facial tissues, shampoo, diapers, under pads, grab bars, and exercise equipment.

KK. **Sex transformation:** Sex transformation surgery and all expenses in connection with such surgery are not included in the benefit package.

LL. **Sexual dysfunction:** Treatment for sexual dysfunction, including medication, counseling, and clinics, is not included in the benefit package.

MM. **Sterilization reversal:** Any service related to reversal of sterilization is not included in the benefit package.

NN. **Substance abuse [~~and/or~~] or tobacco use:** Treatment to prevent the following is not included in the benefit package:

(1) inpatient substance abuse treatment other than detoxification; and

(2) nicotine medications, gums, services, or supplies to aid in the treatment of addiction to tobacco or tobacco products; nicotine withdrawal treatments, including hypnosis, biofeedback, guided imagery, and other forms of relaxation training or subliminal suggestions used to modify tobacco use.

OO. **Therapies:** Therapies including, but not limited to: exercise, massage, hypnotherapy, sensory, hippo, aquatic, oral aversion, visual training, recreational, sleep, stress management, scream, and myotherapy are not included in the benefit package.

PP. **Travel/lodging expenses:** Travel and lodging expenses are not included in the benefit package.

QQ. **Vocational rehabilitation services:** Vocational rehabilitation services are not included in the benefit package.

RR. **War, terrorism, armed forces:** Any illness [~~and/or~~] or injury resulting from war, act of terrorism, or an act of war or service in the armed forces of any country are not included in the benefit package, to the extent covered services of such illness and/or injury are provided through any governmental plan or program.

SS. **Weight loss:** Surgery, medications, and related services for the purpose of weight reduction or control are not included in the benefit package.

TT. **Worker's compensation:** Industrial, work-related, or occupational illnesses, injuries, or conditions subject to federal, state, or other workers' compensation or liability law or other legislation of similar purpose are not included in the benefit package, unless the group is an employer not subject to the New Mexico Workers' Compensation Act or similar legislation.

UU. **Miscellaneous:** The following miscellaneous items are not included in the benefit package:

(1) charges associated with copying or transferring of health information;

(2) consultations by environmental engineers;

(3) devices, medications, and treatments to remove hair due to excessive hair growth;

(4) holistic medicine [~~and/or~~] biofeedback;

(5) treatments, medications, prosthetic devices, and orthotic appliances to treat hair loss;

(6) bone density screening with ultrasound devices; and

(7) telephone visits by a provider or environmental intervention or consultation by telephone for which a charge is made to the member, and getting acquainted visits without physical assessment or diagnostic or therapeutic intervention provided.

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

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE
PART 8 QUALITY MANAGEMENT

8.306.8.9 QUALITY MANAGEMENT: [~~HSD recognizes that strong programs of quality improvement and assurance help ensure that better care is delivered in a cost-effective manner to the member. Under the terms of the medicaid managed care contracts, quality management programs are incorporated into health care delivery and administrative systems.~~] Quality management is both a philosophy and a method of management designed to improve the quality of services; includes both quality assurance and quality improvement activities; and, is incorporated into health care delivery and administrative systems. SCI prefers, but does not require NCQA accreditation for MCOs. The SCI program will require compliance with portions of 8.305.8 NMAC, *Quality Management*, as they apply to the SCI adult (19-64) population, as follows: 8.305.8.10 NMAC, *External Quality Review*; 8.305.8.11 NMAC, *Broad Standards*; 8.305.8.12 NMAC, *Standards For Quality Management And Improvement*; 8.305.8.13 NMAC, *Standards For Utilization Management*; 8.305.8.14 NMAC, *Standards For Credentialing And Recredentialing*; 8.305.8.15 NMAC, *Member Bill Of Rights*; 8.305.8.16 NMAC, *Standards For Preventive Health Services*; with the exception of Paragraph 13 and 14 of Subsection C of 8.305.8.16 NMAC, *Newborn screening* and *Tot-to-teen health checks*; 8.305.8.17 NMAC, *Standards For Medical Record*; and 8.305.8.18 NMAC, *Standards For Access.*
[8.306.8.9 NMAC - N, 7-1-05; A, 7-1-09]

8.306.8.10 DELEGATION: Delegation is a process whereby an MCO gives another entity the authority to perform certain functions on its behalf. The MCO is fully accountable for all delegated activities and decisions made. The MCO shall document its oversight of the delegated activity. The MCO, if contractually obligated, shall delegate behavioral health functions and activities, which may include: quality oversight, utilization management prevention, education, outreach, grievance resolution, data collection and claims payment to the contracted single statewide entity (SE).

A. A mutually agreed upon document between the MCO and the delegated entity will describe:
   (1) the responsibilities of the MCO and the entity to which the activity is delegated;
   (2) the delegated activity;
   (3) the frequency and method of reporting to the MCO;
   (4) the process by which the MCO evaluates the delegated entity's performance; and
   (5) the remedies up to, and including, revocation of the delegation, available to the MCO if the delegated entity does not fulfill its obligations.

B. The MCO shall document evidence that the MCO:
   (1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;
   (2) evaluates regular reports; and
   (3) evaluates semi-annually the delegated entity's activities in accordance with the MCO's expectations and HSD standards.

[8.306.8.10 NMAC - N, 7-1-01; A, 7-1-05; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 10 ENCOUNTERS

8.306.10.11 ENCOUNTER SUBMISSION TIME FRAMES: The MCO shall submit encounter data to HSD within 120 days of the service delivery date, payment date or discharge as defined by HSD. HSD shall establish error thresholds, time frames and procedures for the submission, correction and resubmission of encounter data.
[8.306.10.11 NMAC - N, 7-1-05; A, 7-1-09]

8.306.10.12 ENCOUNTER DATA ELEMENTS: Encounter data elements are [~~based on HIPAA compliant formats developed by CMS and HSD for use in managed care~~] a combination of those elements required by HIPAA-compliant transaction formats, which comprise a minimum core data set for states and MCOs and those required by CMS or HSD for use in managed care. Encounter data elements are specified in the medicaid systems manual. [~~The human services department~~] HSD may increase or reduce or make mandatory or optional, data elements as it deems necessary.
[8.306.10.12 NMAC - N, 7-1-05; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 11 REIMBURSEMENT

8.306.11.9 REIMBURSEMENT:

A. MCO and HSD shall comply with 8.305.11.9 NMAC, *Reimbursement for Managed Care* for the SCI program with the exception of SCI members who are hospitalized at the time of disenrollment from SCI (see below Section B of 8.306.11.9 NMAC). Rates negotiated between HSD and the MCO are considered confidential.

B. **SCI members who disenroll while hospitalized**: If the member is hospitalized at the time of disenrollment from SCI, or upon an approved switch from one SCI Contractor to another, the contractor at the time of admission remains responsible for all covered or approved services until the earliest of: the date of discharge, date of switch to another contractor, date of the member's termination/disenrollment or until the maximum benefit limits are reached.

[~~B.~~] C. **Payment of premiums:** In addition to capitation payments from HSD, the MCO shall receive premium payments as specified by HSD. Premiums will be paid as follows:

(1) **employer premium** amount determined by department; and

(2) **employee or individual premium** determined by department based on the federal poverty limits as follows: 0-100[~~%~~] percent per month, 101-150[~~%~~] percent per month, 151-200[~~%~~] percent per month,

[~~C.~~] D. **Premium timeframes:** Initial premiums are due to the MCO immediately upon enrollment and prior to the 1st day of the month before coverage begins. An employer group or individual member can only receive coverage when the premium has been paid. Capitation payments will not be paid unless verification of premium payment through the roster is received. If payment is not current within that timeframe, the employer group or individual member will not be covered for the next month and will not be able to enroll in an SCI MCO for a period of twelve months for an employer group or six months for an individual member.

[~~D.~~] E. **Responsibility for premium payment:** For members in an employer group, the employer shall be responsible for ensuring payment of the employer and employee share (if any) of premiums. For individuals who are not affiliated with an employer group, the individual or an entity paying on behalf of an individual shall be responsible for payment of both the employer and individual premium amount (if any). If a member who is part of an employer group has met the cost-sharing maximum, as verified by the MCO, HSD shall be responsible for payment of the member's; but not the employer's share of premiums. For individual members not in an employer group who have met the cost-sharing maximum, HSD shall be responsible for the member's share of the premium. The member will continue to be responsible for the employer's share of the premium.

[8.306.11.9 NMAC - N, 7-1-05; A, 3-1-06; A, 4-16-07; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 12 MEMBER GRIEVANCE RESOLUTION

8.306.12.12 APPEALS: An appeal is a request for review by the MCO of an MCO action.

A. Action is defined as:

(1) the denial or limited authorization of a requested service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial, in whole or in part, of payment for a service;

(4) the failure of the MCO to provide services in a timely manner, as defined by HSD; or

(5) the failure of the MCO to complete the authorization request in a timely manner as defined in 42 CFR Section 438.408.

B. **Notice of MCO action:** The MCO shall mail a notice of action to the member and/or provider within 10 days of the date of an action for previously authorized services as permitted under 42 CFR 431.213 and 431.214 and within 14 days of the action for newly requested services. Denials of claims which may result in member financial liability require immediate notification. The notice must contain but not be limited to the following:

(1) the action the MCO has taken or intends to take;

(2) the reasons for the action;

(3) the member's or the provider's right, as applicable, to file an appeal of the MCO action through the MCO;

(4) the member's right to request an HSD fair hearing and what the process would be;

(5) the procedures for exercising the rights specified;

(6) the circumstances under which expedited resolution of an appeal is available and how to request it; and

(7) the member's right to have benefits continue pending resolution of an appeal or fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits.

C. A member may file an appeal of an MCO action within 90 calendar days of receiving the MCO's notice of action. The legal guardian of the member for incapacitated adults, a representative of the member as designated in writing to the MCO, or a provider acting on behalf of the member with the member's written consent, have the right to file an appeal of an action on behalf of the member. The MCO/SE shall consider the member, representative or estate representative of a deceased member as parties to the appeal.

D. The MCO has 30 calendar days from the date the oral or written appeal is received by the MCO to resolve the appeal. The MCO shall appoint at least one person to review the appeal <u>who is qualified to make the decision and</u> was not involved in the initial decision [~~and who is not the subordinate of any person involved in the initial decision~~].

E. The MCO shall have a process in place that that assures that an oral inquiry from a member seeking to appeal an action is treated as an appeal (to establish the earliest possible filing date for the appeal). An oral appeal must be followed by a written appeal within 10 calendar days that is signed by the member. The MCO will make best efforts to assist members as needed with the written appeal.

F. Within five working days of receipt of the appeal, the MCO shall provide the grievant with written notice that the appeal has been received and the expected date of its resolution. The MCO shall confirm in writing receipt of oral appeals, unless the member or the provider requests an expedited resolution.

G. The MCO may extend the 30 day timeframe by 14 calendar days if the member requests the extension, or the MCO demonstrates to HSD that there is need for additional information, and the extension is in the member's interest. For any extension not requested by the member, the MCO must give the member written notice of the extension and the reason for the extension within two working days of the decision to extend the timeframe.

H. The MCO shall provide the member [~~and/or~~] <u>or</u> the member's representative a reasonable opportunity to present evidence, and allegations of the fact or law, in person as well as in writing.

I. The MCO shall provide the member and/or the representative the opportunity, before and during the appeals process, to examine the member's case file, including medical or clinical records, and any other documents and records considered during the appeals process. The MCO shall include as parties to the appeal the member and his or her representative, or the legal representative of a deceased member's estate.

J. For all appeals, the MCO shall provide written notice within the 30-calendar day timeframe of the appeal resolution to the member or the provider, if the provider filed the appeal.

(1) The written notice of the appeal resolution must include, but not be limited to, the following information:

(a) the result(s) of the appeal resolution; and

(b) the date it was completed.

(2) The written notice of the appeal resolution for appeals not resolved wholly in favor of the member must include, but not be limited to, the following information:

(a) the right to request an HSD fair hearing and how to do so;

(b) the right to request receipt of benefits while the hearing is pending, and how to make the request; and

(c) that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.

K. The MCO may continue benefits while the appeal and/or the HSD fair hearing process is pending.

(1) The MCO must continue the member's benefits if all of the following are met:

(a) the member or the provider files a timely appeal of the MCO/SE action [~~and/or~~] or asks for a fair hearing within 13 days from the date on the MCO/SE notice of action;

(b) the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(c) the services were ordered by an authorized provider;

(d) the time period covered by the original authorization has not expired; and

(e) the member requests extension of the benefits.

(2) The MCO shall provide benefits until one of the following occurs:

(a) the member withdraws the appeal;

(b) 13 days have passed since the date of the resolution letter, provided the resolution of the appeal was against the member and the member has taken no further action;

(c) HSD issues a hearing decision adverse to the member; and

(d) the time period or service limits of a previously authorized service has expired.

(3) If the final resolution of the appeal is adverse to the member, that is, the MCO's action is upheld, the MCO may recover the cost of the services furnished to the member while the appeal was pending to the extent that services were furnished solely because of the requirements of this section, and in accordance with the policy in 42 CFR Section 431.230(b).

(4) If the MCO or HSD reverses a decision to deny, limit, or delay services, and these services were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(5) If the MCO or HSD reverses a decision to deny, limit or delay services and the member received the disputed services while the appeal was pending, the MCO must pay for these services.

(6) If HSD reverses a decision to deny eligibility, the potential member can enroll with the MCO, but there will be no retroactive enrollment or benefit coverage under such circumstances.

[8.306.12.12 NMAC - N, 7-1-05; A, 4-16-07; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 13 FRAUD AND ABUSE

8.306.13.10 MANAGED CARE ORGANIZATION REQUIREMENTS: The MCO shall have in place internal controls and policies and procedures that are capable of preventing, detecting, investigating and reporting potential fraud and abuse activities concerning both providers and/or members. The MCO specific internal controls and policies and procedures shall be described in a comprehensive written plan submitted to HSD or its designee for approval. Substantive amendments or modifications to the policies and procedures shall be approved by HSD. The MCO shall maintain procedures for reporting potential and actual fraud and abuse by clients or providers to HSD. The MCO shall:

A. have internal procedures that facilitate preliminary investigating and reporting of potential and actual fraud and abuse to HSD or its designee for further investigation;

B. have specific controls in place for prevention and detection of potential cases of fraud and abuse such as: claims edits, post processing review of claims, provider profiling/exception reporting and credentialing; prior authorizations, utilization/quality management monitoring;

C. have a mechanism to work with HSD or its designee to further develop prevention and detection mechanisms and best practices and to monitor outcomes for SCI;

D. have internal procedures to prevent, detect and investigate program violations to recover funds misspent due to fraudulent or abusive actions;

E. report to HSD the names of all providers identified with aberrant utilization according to provider profiles, regardless of the cause of aberrancy[~~.~~];

F. report to HSD any administrative action taken to limit the ability of an individual or entity to participate in the program;

G. report to HSD any individual or entity that has been excluded from providing items or services to SCI members;

[~~F.~~] H. designate a compliance officer and a compliance committee who are accountable to senior management; [~~and~~]

[~~G.~~] I. provide effective fraud and abuse detection training, administrative remedies for false claims and statements and whistleblower protection under such laws to the MCO's employees that include:

(1) written policies for all employees, agents or contractors that provide detailed information regarding the New Mexico Medicaid False Claims Act, NMSA 1978, and the federal False Claims Act established under sections 3729 through 3733 of Title 31, United States Code, administrative remedies for false claims and statements established under Chapter 38 of Title 31, United States Code, including but not limited to, preventing and detecting fraud, waste and abuse in federal health care programs (as defined in section 1128B (f) of the Social Security Act);

(2) as part of such written policies, detailed provision regarding the MCO's policies and procedures for detecting and preventing fraud, waste and abuse; and

(3) in any employee handbook, a specific discussion of the laws described in Paragraph (1) above, the rights of employees to be protected as whistleblowers, and the contractor's of subcontractor's policies and procedures for detecting and preventing fraud, waste and abuse.

[~~H.~~] J. implement effective lines of communication between the compliance officer and the MCO's employees;

[~~I.~~] K. require enforcement of standards through well-publicized disciplinary guidelines; and

[~~J.~~] L. have a provision for prompt response to detected offenses and for development of corrective action initiatives relating to the MCO's contract.

[8.306.13.10 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 15 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS

8.306.15.9 SERVICES FOR SCI MEMBERS WITH SPECIAL HEALTH CARE NEEDS (SCI-SHCN):

A. SCI-SHCN require a broad range of primary, specialized medical, behavioral health and related services. SCI-SHCN are 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 other individuals. SCI-SHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these individuals so that the MCO can facilitate access to appropriate services. The definition also allows for flexible targeting of individuals based on clinical justification and discontinuing targeted efforts when such efforts are no longer needed.

B. **Identification of enrolled SCI-SHCN:** The MCO shall have written policies and procedures in place with HSD approval, which govern how members with multiple and complex physical and behavioral health care needs shall be identified. The MCOs shall have an internal operational process, in accordance with policy and procedure, to target members for the purpose of applying stratification criteria to identify SCI-SHCNs. The MCO shall employ reasonable effort to identify SCI-SHCNs based at least on the following criteria:

(1) individuals eligible for SSI;
(2) individuals identified by service utilization, clinical assessment, or diagnosis; and
(3) [~~referral~~] individuals referred by family or a public or community program

[8.306.15.9 NMAC - N, 7-1-05; A, 6-1-08; 7-1-09]

8.306.15.11 CHOICE OF SPECIALIST AS PCP: The MCO shall develop and implement policies and procedures governing the process for member selection of a PCP, including the right by an SCI-SHCN to choose a specialist as a PCP, including a psychiatrist in the case of behavioral health. The specialist provider must agree to [~~be the PCP~~] provide all mandated PCP services. See 8.306.6.12 NMAC, *Primary care providers*.
[8.306.15.11 NMAC - N, 7-1-05; A, 7-1-09]

8.306.15.13 CARE COORDINATION FOR SCI-SHCN: The MCOs shall develop policies and procedures to provide care coordination for SCI-SHCN. Please refer to 8.306.9 NMAC, *Coordination of Benefits*, for definition.

A. The MCO shall have an internal operational process, in accordance with policy and procedure, to target medicaid members for purposes of applying stratification criteria to identify those who are potential SCI-SHCN. The contractor will provide HSD with the applicable policy and procedure describing the targeting and stratification process.

B. The MCO shall have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination. If the member has both physical and behavioral health special needs, the MCO and SE shall coordinate care in a timely collaborative manner.

C. The MCO shall have written policies and procedures for educating SCI-SHCN [~~needs~~] about available care coordination and when it may be appropriate.
[8.306.15.13 NMAC - N, 7-1-05; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 306 STATE COVERAGE INSURANCE (SCI)
PART 16 [~~CLIENT~~] MEMBER TRANSITION OF CARE

8.306.16.9 MEMBER TRANSITION OF CARE: Transition of care refers to the movement of member from one health care practitioner or setting to another as his/her condition and care requires change. The MCO shall have the resources, [~~and~~] policies and procedures in place to ensure continuity of care without disruption in service to members and [~~to~~] assure the service provider of payment. The MCO shall actively assist with transition of care issues. During the individual member's SCI recertification of eligibility period and re-enrollment, the member may switch enrollment to a different MCO. Employer groups may also switch MCOs during the group re-enrollment process. Certain members may lose their SCI eligibility while enrolled in an MCO. A member changing from one MCO to another SCI MCO shall continue to receive medically necessary services in an uninterrupted manner.

A. **Member transition:** The MCO shall have policies and procedures that address member identification and the clinical transition and transfer of members into or out of the MCO, including the [~~CLTS~~] CoLTS [~~program~~] MCO.

(1) The MCO shall have policies and procedures that cover potentially large or mass transfer of members into or out of the MCO, including the identification of members currently receiving services.

(2) The MCO shall have policies and procedures covering the transition into the MCO of an individual member, which shall include member education about the MCO, about self-care and the optimization of treatment, and the review and update of existing treatment plans.

(3) The MCO shall have policies and procedures that identify members transferring out of the MCO and ensure the provision of member data and clinical information to the future MCO necessary to avoid delays in member treatment.

B. **Special payment requirement.** The MCO shall be responsible for payment of covered medical services, provided to the member for any month the MCO receives a capitation payment, even if the member has lost SCI eligibility.

C. Tracking of members who are nearing the annual claims benefit maximum or annual bed-day maximum.

(1) MCOs will track dollars paid for claims and hospital inpatient days (including home care days) for each SCI member and identify individuals who are at 50 percent of claims benefits paid out in a benefit year and those who have utilized 80[~~%~~] percent of their available hospital inpatient resources.

(2) Identified members who are at the 50 percent level of claims payments or at 80[~~%~~] percent of hospital inpatient days available will have all care coordinated by the MCO to identify methods to manage care so as to best utilize the remaining dollars and days to maximize care and prevent member from reaching benefit claims and/or hospital day maximum thresholds.

(3) MCO will provide information on these individuals to HSD who will work in conjunction with the MCO to find alternative health care options for these individuals.

D. **Claims processing and payment:** In the event that an MCO's contract with HSD has ended, is not renewed or is terminated, the CONTRACTOR shall remain responsible for processing and paying claims for services delivered through the contract period, but submitted after the MCO's contract has ended.

(1) The MCO shall be required to inform providers in writing, at least 30 days prior to the end of the contract, of the termination of the contract and of the process for providers to submit claims for services provided through the contract end date. The letter shall include the telephone, fax numbers, and the billing address for claims submissions as well as the names of persons to contact with questions.

(2) The MCO shall allow six months to process claims for services provided prior to the contract termination date.

(3) The MCO shall continue to meet timeframes established for processing all claims.

[8.306.16.9 NMAC - N, 7-1-05; A, 6-1-08; A, 7-1-09]

TITLE 8 SOCIAL SERVICES
CHAPTER 352 RECIPIENT HEARING POLICIES
PART 2 RECIPIENT HEARINGS

8.352.2.16 CONTINUATION OF BENEFITS PURSUANT TO TIMELY APPEAL OF HEARING DECISION:

A. Continuation of benefits may be provided to recipients who request a hearing within 13 days of the notice. The notice will include information on the rights to continued benefits and on the recipient's responsibility for repayment if the hearing decision is not in the recipient's favor.

B. Repayment responsibility:

(1) When a recipient appeals an issue of medicaid eligibility as described in 8.100.970 NMAC, *Fair Hearings*, has requested continued benefits pursuant to timely appeal, and the hearing decision upholds HSD's or the involved contractor's proposed action, the overpayment amounts will be calculated as follows:

(a) Fee-for-service month: The medicaid paid amount (paid claims amount) is owed to HSD.

(b) SALUD! enrolled month: HSD is owed the capitation amount plus the medicaid paid claim amount for any carved-out services.

(2) When a recipient appeals a termination, modification, reduction, or suspension of a service as described in this part, and has requested benefit continuation pursuant to timely appeal, and the hearing decision upholds HSD or the contractor's proposed action, the amount owed by the recipient will be calculated as follows: HSD will be owed the medicaid reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision, for fee-for-service and SALUD! enrolled recipients when the service at issue is covered under medicaid fee-for-service. The MCO will be owed and is responsible to collect the medicaid reimbursable amount for the period of time that the service was continued in the interim period pending the hearing decision when the service was provided by the MCO. Collections by the MCO must be used for medicaid Salud! program purposes.

C. For SCI-enrolled clients only: Continuation of benefits may be provided to SCI recipients who are enrolled with an SCI MCO and request a hearing within 13 days of the notice. The notice will include information about the rights to continued benefits and about the recipient's responsibility for repayment if the hearing decision is not in the recipient's favor. If the SCI enrolled client has met his claim benefit maximums (dollars or bed days or prescriptions for the month) or has not paid premiums or paid premiums late, he will not have continuation of benefits when requesting a hearing within 13 days of the notice[~~,~~].

[1-1-00; 8.352.2.16 NMAC - Rn, 8 NMAC 4.MAD.977 & A, 7-1-01; A, 4-16-07; A, 7-1-09]