

TITLE 8 SOCIAL SERVICES
CHAPTER 308 MANAGED CARE PROGRAM
PART 10 CARE COORDINATION

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

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

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

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

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

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

8.308.10.7 DEFINITIONS: [RESERVED]

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

8.308.10.9 CARE COORDINATION:

A. General requirements:

(1) Care coordination services are provided and coordinated with the eligible recipient member and his or her family, as appropriate. Care coordination involves, but is not limited to, the following: planning treatment strategies; developing treatment and service plans; monitoring outcomes and resource use; coordinating visits with primary care and specialists providers; organizing care to avoid duplication of services; sharing information among medical and behavioral care professionals and the member's family; facilitating access to services; and actively managing transitions of care, including participation in hospital discharge planning.

(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, managed care organization (MCO) will document the refusal in the member's file and report it to HSD.

(3) If a native American member requests assignment to a native American care coordinator and the MCO is unable to provide a native American care coordinator to such member, the MCO must ensure that a mutually-agreed upon community health worker is present for all in-person meetings between the care coordinator and the member.

(4) Individuals with special health care needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other members. ISHCN 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 shall facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.

B. Health risk assessment (HRA):

(1) [~~Within 30 calendar days of the member's enrollment with a MCO, the~~] **The** MCO shall

conduct a Human Services Department (HSD) approved health risk assessment (HRA) either by telephone, in person or as otherwise approved by HSD. The HRA is conducted for the purpose of: (a) introducing the MCO to the member; (b) obtaining basic health and demographic information about (c) assisting the MCO in determining the level of care coordination and the need for a Comprehensive Needs Assessment (CNA); [~~services needed by him or her;~~] and (d) determining the need for a nursing facility (NF) or intermediate care facility for individuals with intellectual disabilities (ICF/IID) level of care (LOC) assessment, as applicable. Requirements for health risk assessments are defined in the Managed Care Policy Manual.

~~_____ (2) The MCO shall provide the following to every member during the HRA:
_____ (a) information about the services are available through care coordination;
_____ (b) notification of the care coordination level;
_____ (c) notification of the member's right to request a higher level of care coordination;
_____ (d) requirement for an in person comprehensive needs assessment for the purpose of providing services associated with care coordination Levels 2 or 3; and
_____ (e) information detailing specific next steps for the member.]~~

C. Assignment to care coordination [levels]

~~(1) [Within seven calendar days of completion of the HRA, a member shall be informed of either a Level 1 care coordination assignment or the need for an comprehensive needs assessment to determine the need for the Level 2 or Level 3 care coordination.]~~ The MCO shall conduct a Human Services Department (HSD) approved comprehensive needs assessment (CNA) to assess the member's medical, behavioral health, and long term care needs and determine the care coordination level. Requirements for determination of care coordination levels are defined in the Managed Care Policy Manual.

~~[(2) Within 10 calendar days of completion of the HRA, the member shall receive:
_____ (a) contact information for the contractor's care coordination unit;
_____ (b) the name of the assigned care coordinator if applicable; and
_____ (c) a timeframe during which he or she can expect to be contacted by the care coordination unit or individual care coordinator.~~

~~D. **Level 1 care coordination:** a member who is assigned this level will not receive a comprehensive needs assessment and is not assigned to an individual care coordinator.~~

~~E. **Level 2 and Level 3 care coordination:** a member meeting one of the indicators below shall have a comprehensive needs assessment conducted by the MCO to determine whether the member shall be in Level 2 or Level 3 care coordination. The member:~~

~~_____ (1) is a high cost user as defined by the MCO;
_____ (2) is in out of state medical placement;
_____ (3) is a dependent child in out of home placement;
_____ (4) is a transplant patient;
_____ (5) is identified as having a high risk pregnancy;
_____ (6) has a behavioral health diagnosis including substance abuse that adversely affects his or her life;~~

~~_____ (7) is medically fragile or is an ISHCN;
_____ (8) is designated as an ICF/IID or has a HSD recognized developmental delay (DD);
_____ (9) has high emergency room use, as defined by the MCO ;
_____ (10) has an acute or terminal disease;
_____ (11) is readmitted to the hospital within 30 calendar days of discharge; or
_____ (12) has other indicators as prior approved by HSD.~~

~~F. **Care coordination requirements for Level 1:** Each member will receive, at a minimum, the following care coordination:~~

~~_____ (1) a HRA annual review to determine appropriate care coordination level; and
_____ (2) a review of claims and utilization data at least quarterly to determine if the member is in need of a comprehensive needs assessment and potentially higher care coordination level.~~

~~G. **Comprehensive needs assessment for Level 2 and Level 3 care coordination:**~~

~~_____ (1) The MCO shall schedule an in person comprehensive needs assessment within 14 calendar days of the member receiving notification of the need for a comprehensive needs assessment for a Level 2 or Level 3 care coordination assignment.~~

~~_____ (2) Within 30 calendar days of the HRA, the MCO shall complete the comprehensive needs assessment.~~

~~(3) For all members who become newly eligible on January 1, 2014 or later, the MCO will conduct the HRA within 30 calendar days of the member's enrollment. For members transitioning from legacy medicaid programs on January 1, 2014, the MCO shall conduct the HRA and, if required, a comprehensive needs assessment and a CCP within 180 calendar days.~~

~~(4) The comprehensive needs assessment shall be conducted at least annually or as the care coordinator deems necessary as a result of a request from the member, provider or family member, or as a result of change in the member's health status.~~

~~(5) At a minimum, the comprehensive needs assessment shall:~~

~~(a) assess the member's physical, behavioral health, and long-term care and social needs; and~~

~~(b) identify targeted needs, such as improving health, functional outcomes, or quality of life outcomes.~~

~~H. **Care coordination services requirements for Level 2:** The MCO shall assign a specific care coordinator to each member in Level 2. The care coordinator for a member in Level 2 shall, at the minimum, arrange for or provide the following care coordination:~~

~~(1) the development and implementation of a care plan;~~

~~(2) the monitoring of the care plan to determine if the plan is meeting the members identified needs;~~

~~(3) the assessment of need for assignment to a health home;~~

~~(4) targeted health education, including disease management;~~

~~(5) the annual in-person comprehensive needs assessment;~~

~~(6) the semi-annual in-person visits with the member; and~~

~~(7) the quarterly telephone contact with the member.~~

~~I. **Care coordination requirement for Level 3:** The MCO shall assign a specific care coordinator to each member in Level 3. The care coordinator for a member in Level 3 shall arrange for or provide the following care coordination services:~~

~~(1) the development and implementation of a care plan;~~

~~(2) the monitoring of the care plan to determine if the plan is meeting the member's identified needs;~~

~~(3) the assessment of need for assignment to a health home;~~

~~(4) targeted health education, including disease management;~~

~~(5) the semi-annual in-person comprehensive needs assessment;~~

~~(6) the quarterly in-person visits with the member; and~~

~~(7) monthly telephone contact with the member.]~~

~~[J.] **D. Increase in the level of care coordination services:**~~

~~(1) The MCO shall develop a comprehensive care plan (CCP) for members in care coordination levels 2 and 3. The requirements establishing a need for a comprehensive needs assessment for a higher level of care coordination determination are defined in the Managed Care Policy Manual. [The following triggers, at a minimum, shall identify a member's need for a comprehensive needs assessment for a higher level of care coordination:~~

~~(a) a referral from his or her primary care provider (PCP), specialist, another provider, or from another referral source;~~

~~(b) member's self-referral or a referral by his or her authorized representative;~~

~~(c) a referral from the member's MCO staff or at the request of HSD staff;~~

~~(d) the notification of a hospital admission or emergency room visit; and~~

~~(e) claims or encounter data, hospital admission, discharge data, pharmacy data and data collected through the MCO's utilization management (UM) or the quality management (QM) processes.~~

~~(2) The MCO shall contact the member within 10 calendar days of receiving the referral, or request, or while conducting a data review or becoming aware of a change in the member's condition, to conduct the comprehensive needs assessment for a higher level of care coordination.]~~

~~[K.] **E. Comprehensive care plan requirements:**~~

~~(1) [The MCO shall develop and implement a comprehensive care plan (CCP) for a member in Level 2 or 3 care coordination within 14 business days of the completion of the comprehensive needs assessment.~~

~~(2) The MCO is not required to develop and implement a CCP for a member in Level 1 care coordination.~~

~~(3) The MCO shall ensure that the member and his or her authorized representative~~

~~participate in the development of the CCP.~~

~~(4) The MCO shall ensure that the care coordinator consults with the member's PCP, specialists, behavioral health providers, other providers, and interdisciplinary team experts, as needed in the development of the CCP.]~~ **Requirements for Comprehensive Care Plan development are defined in the Managed Care Policy Manual.**

~~[L.]~~ **E. On-going reporting:** The MCO shall require that the following information about the member's care is shared amongst medical, behavioral health, and long-term care providers:

- (1) drug therapy;
- (2) laboratory and radiology results;
- (3) sentinel events, such as hospitalization, emergencies, or incarceration;
- (4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care or from other behavioral health services; and
- (5) all LOC transitions.

~~[M.]~~ **G. Electronic visit verification (EVV) system:**

(1) The MCO, together with the other MCOs, shall contract with a vendor to implement ~~[aa]~~ **a statewide** electronic visit verification system to monitor the member's receipt of and utilization of a covered community benefit.

~~(2) The MCOs shall ensure that all contracted personal care service providers are participating in the EVV system unless granted an exception as approved by HSD.~~

~~[c]~~ (3) The MCO shall monitor and use information from the electronic verification system to verify that services are provided as specified in the member's CCP, and in accordance with the established schedule, including verification of the amount, frequency, duration, and the scope of each service and that service gaps are identified and addressed immediately, including late and missed visits. The MCO shall monitor all approved services that a member is receiving, including after the MCO's regular business hours.

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

HISTORY OF 8.308.10 NMAC: [RESERVED]