

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, 1/1/2014]

8.308.10.2 SCOPE: This rule applies to the general public.
[8.308.10.2 NMAC - N, 1/1/2014]

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, 1/1/2014]

8.308.10.4 DURATION: Permanent.
[8.308.10.4 NMAC - N, 1/1/2014]

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, 1/1/2014]

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, 1/1/2014]

8.308.10.7 DEFINITIONS: [RESERVED]

8.308.10.8 [RESERVED]
[8.308.10.8 NMAC - N, 1/1/2014; Repealed, 7-1-2016]

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, the 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]~~ employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator.

(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): 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 the member; and (c) confirming the need for a comprehensive needs assessment (CNA); 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 (Section 04 Care Coordination).

C. Assignment to care coordination levels 2 and 3: ~~[For members who require it, the]~~ The MCO shall conduct a HSD approved CNA to assess the member's medical, behavioral health, and long term care needs and determine the care coordination level. Requirements for care coordination level 2 and 3 determinations are defined in the managed care policy manual (Section 04 Care Coordination).

D. Increase in the level of care coordination services: 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 (Section 04 Care Coordination).

E. Comprehensive care plan requirements: The MCO shall develop a comprehensive care plan (CCP) for members in care coordination levels 2 and 3. Requirements for CCP development are defined in the managed care policy manual (Section 04 Care Coordination).

F. 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.

G. Electronic visit verification (EVV) system:

- (1) The MCO, together with the other MCOs, shall contract with a vendor to ~~[implement~~ ~~{an}] operate and administer~~ 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.
- (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, 1/1/2014; A, 7-1-2016; A, xx/xx/xx]

HISTORY OF 8.308.10 NMAC: [RESERVED]