COORDINATED LONG TERM SERVICES
QUALITY MANAGEMENT
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TITLE 8 SOCIAL SERVICES
CHAPTER 307 COORDINATED LONG TERM SERVICES
PART 8 QUALITY MANAGEMENT

8.307.8.1 ISSUING AGENCY: Human Services Department
[8.307.8.1 NMAC - N, 8-1-08]

8.307.8.2 SCOPE: This rule applies to the general public.
[8.307.8.2 NMAC - N, 8-1-08]

8.307.8.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state human services department pursuant to state statute.
[8.307.8.3 NMAC - N, 8-1-08]

8.307.8.4 DURATION: Permanent
[8.307.8.4 NMAC - N, 8-1-08]

8.307.8.5 EFFECTIVE DATE: August 1, 2008, unless a later date is cited at the end of a section.
[8.307.8.5 NMAC - N, 8-1-08]

8.307.8.6 OBJECTIVE: The objective of these rules is to provide policies for the service portion of the New Mexico medicaid coordination of long-term services program.
[8.307.8.6 NMAC - N, 8-1-08, A, 9-1-09]

8.307.8.7 DEFINITIONS: See 8.307.1.7 NMAC.
[8.307.8.7 NMAC - N, 8-1-08]

8.307.8.8 MISSION STATEMENT: The mission of the medical assistance division is to reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the lives of their communities.
[8.307.8.8 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.9 QUALITY MANAGEMENT: 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.
[8.307.8.9 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.10 EXTERNAL QUALITY REVIEW: The state shall retain the services of an external quality review organization (EQRO) in accordance with the Social Security Act Section 1902(a)(30)(C). The coordination of long-term services managed care organizations (CoLTS MCOs) shall cooperate fully with the EQRO and demonstrate adherence to HSD's regulations and quality standards. The EQRO shall not be a competitor of the CoLTS MCO. The CoLTS MCO shall utilize technical assistance and guidelines offered by the EQRO, when recommended or directed by the state.
[8.307.8.10 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.11 BROAD STANDARDS:

A. **Data requirement:** The CoLTS MCO shall submit a copy of its performance measure/performance improvement data submission tool to HSD or its designee. The CoLTS MCO is expected to use and rely upon HEDIS-like data as an important measure of performance for HSD. The CoLTS MCO is expected to use HEDIS-like data as a measure of performance and to incorporate the results of each year's data submission to its QI/QM plan.

B. **Mental health reporting requirement:** The SE shall collect and submit a statistically valid New Mexico consumer/family satisfaction project (C/FSP) survey for both the medicaid adult and child family population annually. The annual C/FSP survey shall be conducted on a calendar year basis and shall include non-survey indicators defined by HSD each contract calendar year. The SE shall submit to HSD a written analysis of the annual C/FSP report for medicaid based on the aggregate survey data results for both the child/family and adult medicaid populations.

C. **Collection of clinical data:** The CoLTS MCO shall collect clinical data utilizing a sample of clinical records sufficient to produce statistically valid results. The sample shall support stratification of the population served according to parameters requested by the state.

D. **Behavioral health data (SE only):** For reporting purposes, BH data for medicaid managed care members shall include all behavioral health services regardless of setting or location. Data shall be collected and reported as required to HSD.

E. **Provision of emergency services:** The CoLTS MCO shall ensure that acute general hospitals are reimbursed for emergency services provided in compliance of federal mandates, such as the "anti-dumping" law in the Omnibus Reconciliation Act of 1989, P.L. (101-239) and 42 U.S.C. Section 1395dd. (1867 of the Social Security Act). The SE shall ensure that the UNM psychiatric emergency room is reimbursed for emergency services provided.

F. **Disease reporting:** The CoLTS MCO shall require its service providers to comply with disease reporting required by the "New Mexico Regulations Governing the Control of Disease and Conditions of Public Health Significance, 1980".

G. **Other required reporting:** The CoLTS MCO agrees to comply with all applicable standards, orders and regulations issued pursuant to the Clean Air Act, 42 U.S.C. Section 7401 et seq., and the Federal Water Pollution Control Act, as amended and codified at 33 U.S.C. Section 1251 et seq. Any violation of this provision shall be reported to the US department of health and human services (HHS) and the appropriate regional office of the environmental protection agency.

[8.307.8.11 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.12 STANDARDS FOR QUALITY MANAGEMENT AND IMPROVEMENT:

A. **Program structure:** The CoLTS MCO/SE's QM and QI structures and processes shall be planned, systematic, clearly defined, and at least as stringent as federal requirements. Responsibilities shall be assigned to appropriate individuals. CoLTS MCO/SE's QM/QI activities shall demonstrate the linkage of quality improvement projects to findings from multiple quality evaluations, such as the external quality review (ERQ) annual evaluation; annual HEDIS-like indicators, state defined performance measures and consumer satisfaction surveys and service provider surveys.

(1) The QM/QI program shall include: specific targeted goals, objectives and structures that cover the CoLTS MCO/SE's immediate objectives for each contract year or calendar year; and long-term objectives for the entire contract period. The annual plan shall include the specific interventions to be utilized to improve the quality targets, as well as the timeframes for evaluation.

(2) Internal processes shall be transparent and accountable.

(3) The program description shall address QI for all major demographic groups within the CoLTS MCOor SE.

(4) The QM/QI description/work plan shall address the process by which the CoLTS MCO/SE adopts, reviews, updates and disseminates evidence-based clinical practice guidelines for the provision of services for acute and chronic conditions, including behavioral health (SE only). The CoLTS MCO/SE shall involve its service providers in this process.

(5) The program description/work plan shall address activities to improve the health status of members with chronic conditions, including identification of such members; implementation of services and programs to assist such members in managing their conditions, including behavioral health; and informing service providers about the programs and services for members assigned to them.

(6) The QM/QI annual written evaluation shall include a review of completed and continuing QI activities that address quality of clinical care and quality of service; determination and documentation of any demonstrated improvements in quality of care and service.

B. **Program operations:** The QM/QI committee shall:

(1) review and evaluate the results of QI activities, institute needed actions, and ensure follow-up as appropriate;

(2) have contemporaneous dated and signed minutes that reflect all QM/QI committee decisions and actions;

(3) ensure that the CoLTS MCO/SE coordinates the QM/QI program with performance monitoring activities throughout the organization, including, but not limited to: utilization management; fraud and abuse detection; credentialing; monitoring and resolution of member grievances and appeals; assessment of member satisfaction; and medical records review; and

(4) ensure that the results of QM/QI activities, performance improvement projects and reviews are used to improve quality.

C. **Health services contracting:** Contracts with individual and institutional service providers shall specify compliance with the CoLTS MCO/SE's QM/QI program.

D. **Continuous quality improvement/total quality management:** The CoLTS MCO/SE shall ensure that both clinical and nonclinical aspects of its quality management program are based on principles of continuous quality improvement/total quality management (CQI/TQM). Such an approach shall include at least the following:

(1) recognition that opportunities for improvement are unlimited;

(2) assurance that the QI process is data driven;

(3) use of member and service provider input to develop CQI activities; and

(4) require ongoing measurement of clinical and non-clinical effectiveness and programmatic improvements.

E. **Member satisfaction:** The CoLTS MCO shall implement methods aimed at member satisfaction with the active involvement and participation of members and their families, whenever possible, and ensure results of member satisfaction surveys are used to improve quality.

(1) The CoLTS MCO/SE shall add questions about individuals with special health care needs (ISHCN) to all consumer surveys, as appropriate.

(2) The CoLTS MCO/SE shall disseminate results of the member satisfaction survey to service providers, providers, the state, and CoLTS MCO/SE members.

(3) The CoLTS MCO shall cooperate with the state in conducting a network provider satisfaction survey.

(4) The CoLTS MCO/SE shall evaluate member grievances and appeals for trends and specific problems.

(5) The CoLTS MCO/SE shall use input from the consumer advisory board to identify opportunities for improvement; and

(6) The CoLTS MCO/SE shall implement interventions and measure the effectiveness of these interventions.

F. **Health management systems:**

(1) The CoLTS MCO/SE shall actively work to improve the health status of its members with chronic physical and behavioral health conditions, utilizing best practices throughout its provider networks.

(a) The CoLTS MCO shall proactively identify members with chronic medical conditions, and offer appropriate outreach, services and programs to assist in managing and improving their chronic conditions. The SE shall proactively identify members with chronic behavioral health conditions and offer appropriate outreach, services and programs to assist in managing and approving their chronic behavioral health patient outcomes.

(b) The CoLTS MCO/SE shall proactively identify ISHCN who have or are at increased risk for a chronic physical or behavioral health condition.

(c) The CoLTS MCO/SE shall inform and educate its service providers about the use of health management programs for CoLTS MCO/SE members.

(d) The CoLTS MCO/SE shall facilitate, through their committee structure, a process for identifying and addressing the appropriate use of psychopharmacological medications and adverse drug reactions.

(2) The CoLTS MCO/SE shall pursue continuity of services for members. The CoLTS MCO/SE shall:

(a) have a defined process to ensure prompt member notification by its service providers of abnormal results of diagnostic laboratory, diagnostic imaging and other testing, and this will be documented in the medical record;

(b) ensure that the processes for follow-up visits, consultations and referrals are consistent with high quality care and service and do not create a clinically significant impediment to timely medically necessary services; the determination of medical necessity shall be based on HSD's medical necessity definition and its application; and

(c) ensure that all medically necessary referrals are arranged and coordinated by either the referring service provider or by the CoLTS MCO/SE's service coordination unit;

(d) implement policies and procedures to ensure that continuity and coordination of services occur across practices and service providers and between CoLTS MCO and SE; in particular, the CoLTS MCO/SE shall coordinate, in accordance with applicable state and federal privacy laws, with other state agencies. The SE shall coordinate services with all applicable state agencies comprising the collaborative;

(e) assist and monitor the transitions between service providers for continuity of services in order to avoid abrupt changes in treatment plans and caregivers for members currently being served; and

(f) shall develop a policy and procedure that addresses the promotion of member compliance with follow up appointments, consultation/referrals and diagnostic laboratory, imaging and other testing.

G. **Clinical practice guidelines:** The CoLTS MCO/SE shall disseminate to service providers recommended practice guidelines, practice parameters, consensus statements and specific criteria for the provision of acute and chronic physical and behavioral health care services.

(1) The CoLTS MCO/SE shall select the clinical issues to be addressed with clinical guidelines based on the needs of the served populations.

(2) The clinical practice guidelines shall be evidence-based.

(3) The CoLTS MCO/SE shall involve board certified service providers who are appropriate to the clinical issue in the development and adoption of clinical practice guidelines.

(4) The CoLTS MCO/SE shall develop a mechanism for reviewing the guidelines when clinically appropriate, but at least every two years, and updating them as necessary.

(5) The CoLTS MCO/SE shall distribute the guidelines to the appropriate service providers and to HSD or its designee.

(6) The CoLTS MCO/SE shall annually measure service provider performance against at least two important aspects of three clinical practice guidelines and determine consistency of decision-making based on the clinical practices guidelines.

(7) Decision-making in utilization management, member education, interpretation of covered benefits and other areas shall be consistent with those guidelines.

(8) The CoLTS MCO's shall implement HSD-approved targeted disease management protocols for chronic diseases or conditions, such as asthma, diabetes, and hypertension that are appropriate to meet the needs of the varied served populations. The CoLTS MCO shall:

(a) improve the ability to manage chronic illnesses/diseases in order to meet goals based on jointly established targets;

(b) provide comprehensive disease management for a minimum of two chronic diseases using strategies consistent with nationally recognized disease management guidelines;

(c) submit cumulative data-driven measurements from each of its disease management programs to the state according to contract requirements; all disease management data submitted to the state shall be New Mexico medicaid-specific;

(d) submit to the state annually the CoLTS MCO disease management plan, which includes a program description, overall program goals, measurable objectives, targeted interventions, and its methodology used to identify other diseases for potential disease management programs;

(e) submit to the state annually a quantitative evaluation of the efficacy of the prior year's disease management program; and

(f) demonstrate consistent improvement in the overall disease management program goals annually or maintain mutually agreed upon level of performance with a report to the state.

(9) The CoLTS MCOs shall develop targets with protocols and procedures that address the needs of individuals with disabilities, who are not ill, and address quality-of-life enhancing targets needed by people with disabilities.

H. **Quality assessment and performance improvement:** The CoLTS MCO/SE shall achieve required minimum performance levels on performance measures as established by HSD. The quality measures may be used in part to determine the CoLTS MCO/SE assignment algorithm. The CoLTS MCO/SE shall achieve minimum performance levels set by HSD for each performance measure. The CoLTS MCO/SE shall measure its performance, using claims, encounter data, and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD. The CoLTS MCO shall: implement performance measures and tracking measures defined by HSD or its designee in collaboration with the CoLTS MCO; the CoLTS MCO shall monitor these measures on an ongoing basis and report results to HSD or its designee; identify and monitor performance measures and tracking measures of home and community-based service delivery, and implement activities designed to improve the coordination of CoLTS services; demonstrate consistent and sustainable patterns of improvement from year to year in the overall member satisfaction survey results, disease management initiatives and performance measures; review outcome data at least quarterly for performance improvement recommendations and interventions; and provide mechanisms for monitoring, addressing and correcting any evidence of cost-shifting practices by network providers.

(1) Disease management/performance measures shall be identified at the beginning of each contract year by HSD.

(2) The CoLTS MCO/SE shall measure its performance, using claims, encounter data and other predefined sources of information, and report its performance on each measure to HSD at a frequency to be determined by HSD.

I. **Effectiveness of the QM/QI program:** The CoLTS MCO/SE shall evaluate the overall effectiveness of its QM/QI program and demonstrate improvements in the quality of clinical care and the quality of service to its members. An annual written evaluation, submitted to HSD, shall include a description of completed and ongoing quality improvement activities; trending of measures; and analysis of demonstrated improvement of identified opportunities for improvement.

[8.307.8.12 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.13 STANDARDS FOR UTILIZATION MANAGEMENT: The CoLTS MCO/SE's UM programs shall be based on standard external national criteria, where available, and established clinical criteria, that are congruent with HSD's medical necessity service definition. The CoLTS MCO/SE shall request approval from HSD of all UM and level of care criteria not otherwise derived from a nationally recognized resource such as Milliman, Apollo or InterQual. Utilization management (UM) standards shall be applied consistently so quality services are provided in coordinated fashion with neither over-nor under-utilization. The CoLTS MCO/SE's UM program shall assign responsibility to appropriately qualified, educated, trained, and experienced individuals to authorize services through fair, consistent and competent decision making to assure equitable access to services. These standards shall also apply to pharmacy utilization management including the formulary exception process. Services provided within the IHS and tribal 638 networks are not subject to prior authorization requirements, except for behavioral health residential treatment center (RTC) services.

A. **Program design:**

(1) A written description of the UM program shall outline the program structure and include a clear definition of authority and accountability for all activities between the CoLTS MCO and entities to which the CoLTS MCO/SE delegates UM activities.

(2) A designated physician shall have substantial involvement in the design and implementation of the UM program.

(3) The description shall include the scope of the program; the processes and information sources used to determine benefit coverage; clinical necessity, appropriateness and effectiveness; policies and procedures to evaluate service coordination, discharge criteria, levels of care, triage decisions and cultural competence of service delivery; processes to review, approve and deny services; and processes to evaluate service outcomes; and a plan to improve outcomes, as needed. The member's individualized service plan (ISP) priorities and prolonged service authorizations applicable for individuals with chronic conditions shall be considered in the decision-making process.

(4) The UM program shall be evaluated and approved annually by senior management and the medical director or the QI committee.

(5) The UM program shall include policies and procedures for monitoring inter-rater reliability of all individuals performing utilization review. The procedures shall include a monitoring and education process for all utilization review staff identified as not meeting 90 percent agreement on test cases, until adequately resolved.

B. **UM decision criteria:** The CoLTS MCO/SE shall use written utilization review decision criteria that are based on reasonable medical evidence, consistent with the New Mexico medicaid definition for medically necessary services, and that are applied in a fair, impartial and consistent manner.

(1) The CoLTS MCO/SE shall ensure that the services are no less than the amount, duration and scope for the same services furnished to members under fee-for-service medicaid as set forth in 42 CFR Section 440.230. The CoLTS MCO/SE may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the beneficiary's diagnosis, type of illness or condition.

(2) The criteria for determining medical necessity shall be academically defensible, and based on national standards of practice when such standards are available; and acceptable to the CoLTS MCO/SE's medical (or behavioral health) director, peer consultants and relevant local providers. The CoLTS MCO/SE shall specify what constitutes medically necessary services in a manner that is no more restrictive than that used by HSD. The CoLTS MCO/SE must be responsible for covered services related to:

(a) the prevention, diagnosis, and treatment of health impairments; and

(b) the ability to attain, maintain, or regain functional capacity.

(3) Criteria for determination of medical appropriateness shall be clearly documented.

(4) The CoLTS MCO/SE shall maintain evidence that the criteria has been reviewed and updated at specified intervals.

(5) The CoLTS MCO/SE shall state in writing how service providers can obtain UM criteria and shall provide criteria to its service providers upon request.

(6) The CoLTS MCO/SE shall have written policies and procedures describing how health professionals may access the clinical information used to support UM decisions.

C. **Authorization of services:** The CoLTS MCO/SE shall:

(1) have a policy and procedure in place for authorization requests and decisions;

(2) require subcontractors have written policies and procedures for authorization requests and decisions;

(3) ensure consistent application of review criteria for authorization decisions; and

(4) consult with requesting providers when appropriate to secure additional information.

D. **Use of qualified professionals:** The CoLTS MCO/SE shall utilize appropriately licensed and experienced health care practitioners whose education, training, experience and expertise are commensurate with the UM reviews and are qualified to supervise review decisions.

E. **Timeliness of decisions and notifications:** The CoLTS MCO/SE shall make utilization decisions and notifications in a timely manner that accommodate the clinical urgency of the situation and minimize disruption in the provision and continuity of health care services. The following timeframes are required and shall not be affected by "pend" decisions.

(1) **Precertification - routine:**

(a) **Decision:** For precertification of non-urgent (routine) services, the CoLTS MCO/SE shall make a decision within 14 calendar days from receipt of request for service.

(b) **Notification:** For authorization or denial of non-urgent (routine) services, the CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of non-urgent (routine) services, the CoLTS MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision.

(2) **Precertification - urgent:**

(a) **Decision and notification:** For precertification of urgent services, the CoLTS MCO/SE shall make a decision and notify the service provider of the decision within 72 hours of receipt of request. For authorization of urgent services that result in a denial, the CoLTS MCO/SE shall notify both the member and service provider that an expedited appeal has already occurred.

(b) **Confirmation - denial:** For denial of urgent services, the CoLTS MCO/SE shall give the member and service provider written or electronic confirmation of the decision within two working days of making the decision. The CoLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(3) **Precertification - residential services (SE only):** For precertification of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request of services.

(4) **Precertification - extensions:** For precertification decisions of non-urgent or urgent services, a 14 calendar day extension may be requested by the member or service provider. A 14 calendar day extension may also be requested by the CoLTS MCO/SE. The CoLTS MCO/SE must justify in the UM file the need for additional information and that the 14 day extension is in the member's interest.

(5) **Concurrent - routine:**

(a) **Decisions:** For concurrent review of routine services, the CoLTS MCO/SE shall make a decision within 10 working days of the receipt of the request.

(b) **Notification:** For authorization or denial of routine continued stay, the CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision.

(c) **Confirmation - denial:** For denial of routine continued stay, the CoLTS MCO/SE shall give the member and service provider written or electronic confirmation within one working day of the decision. The CoLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(6) **Concurrent - urgent:**

(a) **Decision:** For concurrent review of urgent services, the CoLTS MCO/SE shall make a decision within one working day of receipt of request.

(b) **Notification:** For authorization or denial of urgent continued stay, the CoLTS MCO/SE shall notify a service provider of the decision within one working day of making the decision. The CoLTS MCO/SE shall initiate an expedited appeal for all denials of concurrent urgent services.

(c) **Confirmation - denial:** For denial of urgent continued stay, the CoLTS MCO/SE shall give the member and service provider written or electronic confirmation within one working day of the decision. The CoLTS MCO/SE shall provide written confirmation of its decision within two working days of providing notification of a decision if the initial notification was not in writing.

(7) **Concurrent-residential services (SE only):** For concurrent reviews of RTC, TFC and group home, the SE shall make a decision within five working days from receipt of request for service. Timelines for routine and urgent concurrent shall apply.

(8) **Administrative/technical denials:** When the CoLTS MCO/SE denies a request for services due to the requested service not being covered by medicaid or due to service provider noncompliance with the CoLTS MCO/SE's administrative policies, the CoLTS MCO/SE shall adhere to the timelines cited above for decision making, notification and written confirmation.

F. **Use of clinical information:** When making a determination of coverage based on medical necessity, the CoLTS MCO/SE shall obtain relevant clinical information and consult with the treating service provider, as appropriate.

(1) A written description shall identify the information required and collected to support UM decision making.

(2) A thorough assessment of the member's needs based on clinical appropriateness and necessity shall be performed.

(3) There shall be documentation that relevant clinical information is gathered consistently to support UM decision making. The CoLTS MCO/SE UM policies and procedures will clearly define in writing for service providers what constitutes relevant clinical information, as well as how to accurately submit authorization requests.

(4) The clinical information requirements for UM decision making shall be made known in advance to relevant treating service providers.

G. **Denial of services:** A "denial" is a non-authorization of a request for care or services. The CoLTS MCO/SE shall clearly document in the UR file a reference to the specific provision guideline, protocol or other criteria on which the denial decision is based, and communicate the reason for each denial.

(1) The CoLTS MCO/SE shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional

who has appropriate clinical expertise in treating the member's condition or disease, such as the CoLTS MCO/SE medical director.

(2) For a health service determined to be medically necessary, but for which the level of care (setting) is determined to be inappropriate, the CoLTS MCO/SE shall deny that which was determined to be inappropriate, and recommend an appropriate alternative level of care (setting).

(3) The reasons for review decisions (approve/deny) shall be clearly documented and communicated to the requesting practitioner.

(4) The CoLTS MCO/SE shall send written notification to the member of the reason for each denial based on medical necessity and to the provider, as appropriate.

(5) The CoLTS MCO/SE shall make available to a requesting service provider a physician reviewer to discuss, by telephone, denial decisions based on medical necessity.

(6) The CoLTS MCO/SE shall recognize that a utilization review decision made by the designated HSD official resulting from a fair hearing is final and shall be honored by the CoLTS MCO/SE, unless the CoLTS MCO/SE successfully appeals the decision through judicial hearing or arbitration.

H. **Compensation for UM activities:** Each CoLTS MCO/SE contract must provide that, consistent with 42 CFR Sections 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

I. **Evaluation and use of new technologies:** The CoLTS MCO/SE and its delegates shall evaluate the inclusion of new medical technology and the new applications of existing technology in the benefit package. This includes the evaluation of clinical procedures and interventions, drugs and devices.

(1) The CoLTS MCO/SE shall have a written description of the process used to determine whether new medical technology and new uses of existing technologies shall be included in the benefit package.

(a) The written description shall include the decision variables used by the CoLTS MCO/SE to evaluate whether new medical technology and new applications of existing technology shall be included in the benefit package.

(b) The process shall include a review of information from appropriate government regulatory bodies as well as published scientific evidence.

(c) Appropriate professionals shall participate in the process to decide whether to include new medical technology and new uses of existing technology in the benefit package.

(2) A CoLTS MCO/SE shall not deem a technology or its application as experimental, investigational or unproven and deny coverage unless that technology or its application fulfills the definition of "experimental, investigational or unproven" contained in 8.325.6 NMAC, *Experimental or Investigative Procedures, Technologies or Non-Drug Therapies.*

J. **Evaluation of the UM process:** The CoLTS MCO/SE shall evaluate member and service provider satisfaction with the UM process based on member and service provider satisfaction survey results. The CoLTS MCO/SE shall forward the evaluation results to HSD or its designee.

K. **HSD access:** HSD or its designee shall have access to the CoLTS MCO/SE's UM review documentation on request.

[8.307.8.13 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.14 STANDARDS FOR CREDENTIALING AND RECREDENTIALING: The CoLTS MCO/SE shall document the mechanism for credentialing and recredentialing of service providers with whom it contracts or employs to treat members outside the in-patient setting and who fall under its scope of authority. The documentation shall include, but not be limited to, defining the scope of service providers covered, the criteria and the primary source verification of information used to meet the criteria, the process used to make decisions, and the extent of delegated credentialing or recredentialing arrangements. The credentialing process shall be completed within 45 days for professional and institutional providers identified in NCQA credentialing requirements. The 45-day turn around time will apply to clean files only and shall not apply to incomplete credentialing applications or applications that reveal a history of sanctions, malpractice issues, or other anomalies requiring further review of information. For providers that do not require credentialing, e.g., environmental modification providers, the CoLTS MCO will document that these providers are licensed to do business in New Mexico. The CoLTS MCOs shall all use the same primary source verification entity unless there are more cost effective alternatives approved by HSD.

A. **Service provider participation:** The CoLTS MCO/SE shall have a process for receiving input from participating service providers regarding credentialing and recredentialing of service providers.

B. **Primary source verification:** The CoLTS MCO/SE shall verify the following information from primary sources during credentialing:

(1) a current valid license to practice;

(2) the status of clinical privileges at the institution designated by the service provider as the primary admitting facility, if applicable;

(3) valid drug enforcement agency (DEA) or controlled substance registration (CSR) certificate, if applicable;

(4) education and training of service providers, including graduation from an accredited professional program and the highest training program applicable to the academic or professional degree, discipline and licensure of the service provider;

(5) board certification if the service provider states on the application that the service provider is board certified in a specialty;

(6) current, adequate malpractice insurance, according to the CoLTS MCO/SE's policy and history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(7) primary source verification shall not be required for work history.

C. **Credentialing application:** The CoLTS MCO/SE shall use the HSD-approved credentialing form. The service provider shall complete a credentialing application that includes a statement by the applicant regarding:

(1) ability to perform the essential functions of the positions, with or without accommodation;

(2) lack of present illegal drug use;

(3) history of loss of license and felony convictions;

(4) history of loss or limitation of privileges or disciplinary activity;

(5) sanctions, suspensions or terminations imposed by medicare or medicaid; and

(6) applicant attests to the correctness and completeness of the application.

D. **External source verification:** Before a service provider is credentialed, the CoLTS MCO/SE shall receive information on the service provider from the following organizations and shall include the information in the credentialing files:

(1) national practitioner data bank, if applicable to the service provider type;

(2) information about sanctions or limitations on licensure from the following agencies, as applicable:

(a) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(b) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(c) state board of dental examiners;

(d) state board of podiatric examiners;

(e) state board of nursing;

(f) the appropriate state licensing board for other service provider types, including behavioral health; and

(g) other recognized monitoring organizations appropriate to the service provider's discipline;

(3) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance plan (SCHIP), and all federal health care programs (as defined in section 1128B(f) of the Social Security Act; sanctions by medicare, medicaid, the state children's health insurance program or any federal care program.

E. **Evaluation of service provider site and medical records.** The CoLTS MCO shall perform an initial visit to the offices of potential primary care providers, obstetricians, and gynecologists and the SE shall perform an initial visit to the offices of potential high volume behavioral health care service providers, prior to acceptance and inclusion as participating service providers. The CoLTS MCO/SE shall determine its method for identifying high volume behavioral health service providers.

(1) The CoLTS MCO/SE shall document a structured review to evaluate the site against the CoLTS MCO/SE's organizational standards and those specified by the coordination of long-term services contract.

(2) The CoLTS MCO/SE shall document an evaluation of the medical record keeping practices at each site for conformity with the CoLTS MCO/SE's organizational standards.

F. **Recredentialing:** The CoLTS MCO/SE shall have formalized recredentialing procedures.

(1) The CoLTS MCO/SE shall recredential its service providers at least every three years. The CoLTS MCO/SE shall verify the following information from primary sources during recredentialing.

(a) a current valid license to practice;

(b) the status of clinical privileges at the hospital designated by the service provider as the primary admitting facility;

(c) valid DEA or CSR certificate, if applicable;

(d) board certification, if the service provider was due to be recertified or became board certified since last credentialed or recredentialed;

(e) history of professional liability claims that resulted in settlement or judgment paid by or on behalf of the service provider; and

(f) a current, signed attestation statement by the applicant regarding:

(i) ability to perform the essential functions of the position, with or without accommodation;

(ii) lack of current illegal drug use;

(iii) history of loss or limitation of privileges or disciplinary action; and

(iv) current professional malpractice insurance coverage.

(2) There shall be evidence that, before making a recredentialing decision, the CoLTS MCO has received information about sanctions or limitations on licensure from the following agencies, if applicable:

(a) the national practitioner data bank;

(b) medicare and medicaid;

(c) state board of medical examiners, state osteopathic examining board, federation of state medical boards or the department of professional regulations;

(d) state board of chiropractic examiners or the federation of chiropractic licensing boards;

(e) state board of dental examiners;

(f) state board of podiatric examiners;

(g) state board of nursing;

(h) the appropriate state licensing board for other service provider types;

(i) other recognized monitoring organizations appropriate to the service provider's discipline; and

(j) HHS/OIG exclusion from participation in medicare, medicaid, the state children's health insurance program and all federal health care programs.

(3) The CoLTS MCO/SE shall incorporate data from the following sources in its recredentialing decision-making process for service providers:

(a) member grievances and appeals;

(b) information from quality management and improvement activities; and

(c) medical record reviews conducted under Subsection E of 8.307.8.14 NMAC, *standards for credentialing and recredentialing.*

G. **Imposition of remedies:** The CoLTS MCO/SE shall have policies and procedures for altering the conditions of the service provider's participation with the CoLTS MCO/SE based on issues of quality of care and service. These policies and procedures shall define the range of actions that the CoLTS MCO/SE may take to improve the service provider's performance prior to termination.

(1) The CoLTS MCO/SE shall have procedures for reporting to appropriate authorities, including HSD or its designee, serious quality deficiencies that could result in a service provider's suspension or termination.

(2) The CoLTS MCO/SE shall have an appeal process by which the CoLTS MCO/SE may change the conditions of a service provider's participation based on issues of quality of care and service. The CoLTS MCO/SE shall inform service providers of the appeal process in writing.

H. **Assessment of organizational providers:** The CoLTS MCO/SE shall have written policies and procedures for the initial and ongoing assessment of organizational providers with whom it intends to contract or which it is contracted. At least every three years, the CoLTS MCO/SE shall:

(1) confirm that the service provider has been certified by the appropriate state certification agency, when applicable; behavioral health organizational providers and services are certified by the following:

(a) DOH is the certification agency for organizational services and providers that require certification, except for child and adolescent behavioral health services; and

(b) CYFD is the certification agency for child and adolescent behavioral health organizational services and providers that require certification.

(2) confirm that the service provider has been accredited by the appropriate accrediting body or has a detailed written plan expected to lead to accreditation within a reasonable period of time; behavioral health organizational providers and services are accredited by the following:

(a) adult behavioral health organizational services or providers are accredited by the council on accreditation of rehabilitation facilities (CARF);

(b) child and adolescent accredited residential treatment centers are accredited by the joint commission on accreditation of healthcare organizations (JCAHO); other child behavioral health organizational services or providers are accredited by the council on accreditation (COA); and

(c) organizational services or providers who serve adults, children and adolescents are accredited by either CARF or COA.

[8.307.8.14 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.15 MEMBER BILL OF RIGHTS: The CoLTS MCO/SE shall have policies and procedures governing member rights and responsibilities and require adherence by all providers, including CoLTS MCO-contracted providers. The following subsections shall be known as the "member bill of rights".

A. **Members' rights:**

(1) Members shall have the right to be treated equitably and with respect and recognition of their dignity and need for privacy.

(2) Members shall have the right to receive health care services in a non-discriminatory fashion.

(3) Members who have a disability shall have the right to receive any information in an alternative format in compliance with the Americans with Disabilities Act.

(4) Members or their legal guardians shall have the right to participate with their service providers in decision making in all aspects of their health services, including the course of treatment development, acceptable treatments and the right to refuse treatment.

(5) Members or their legal guardians shall have the right to informed consent.

(6) Members or their legal guardians shall have the right to choose a surrogate decision-maker to be involved as appropriate, to assist with service decisions.

(7) Members or their legal guardians shall have the right to seek a second opinion from a qualified health care professional within the CoLTS MCO/SE network, or the CoLTS MCO/SE shall arrange for the member to obtain a second opinion outside the network, at no cost to the member. A second opinion may be requested, when the member or member's legal guardian needs additional information regarding recommended treatment or believes the service provider is not authorizing requested services.

(8) Members or their legal guardians shall have a right to voice grievances about the services provided by the CoLTS MCO/SE and to make use of the CoLTS MCO/SE's grievance process and the HSD fair hearings process without fear of retaliation.

(9) Members or their legal guardians shall have the right to choose from among the available service providers within the limits of the plan network and its referral and prior authorization requirements.

(10) Members or their legal guardians shall have the right to make their wishes known through advance directives regarding health service decisions consistent with federal and state laws and regulations.

(11) Members or their legal guardians shall have the right to access the member's medical records in accordance with the applicable federal and state laws and regulations.

(12) Members or their legal guardians shall have the right to receive information about: the CoLTS MCO/SE, its health care services, how to access those services, and the CoLTS MCO/SE network providers.

(13) Members or their legal guardians shall have the right to be free from harassment by the CoLTS MCO/SE or its network providers in regard to contractual disputes between the CoLTS MCO/SE and providers.

(14) Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal or state of New Mexico regulations on the use of restraints and seclusion.

(15) Members or their legal guardians shall have the right to select a CoLTS MCO and exercise switch enrollment rights without threats or harassment.

B. **Standards for consumer/participant direction**

(1) Members have direct involvement, control, and choice in assessing his/her own needs and identifying, accessing, and managing services and supports to meet those needs. When appropriate, families or representatives shall be involved in the process. In consumer/participant direction, the process shall also include a member's active participation in making key service plan and service priority decisions as well as evaluating the quality of the services rendered.

(2) CoLTS MCO shall recognize a continuum of different levels of informed decision-making authority, control and autonomy, to the extent desired by the member, at any given point in the course of his/her participation in CoLTS. These levels shall range from a member choosing not to direct his/her services and instead deferring to trusted family members or representatives of his/her choosing.

(3) Ensure that a member can move across the continuum of decision-making, depending upon his/her needs and circumstances, and shall support the member in his/her decision regarding the level of consumer/participant direction chosen.

C. **Members' responsibilities:** Members or their legal guardians shall have certain responsibilities that will facilitate the treatment process.

(1) Members or their legal guardians shall have the responsibility to provide, whenever possible, information that the CoLTS MCO/SE and service providers need in order to care for them.

(2) Members or their legal guardians shall have the responsibility to understand the member's health problems and to participate in developing mutually agreed upon treatment goals.

(3) Members or their legal guardians shall have the responsibility to follow the plans and instructions for services that they have agreed upon with their service providers or to notify service providers if changes are requested.

(4) Members or their legal guardians shall have the responsibility to keep, reschedule or cancel an appointment rather than to simply not show up.

D. **CoLTS MCO/SE responsibilities:**

(1) The CoLTS MCO/SE shall provide a member handbook to its members and to potential members who request the handbook and have the handbook accessible via the internet. The CoLTS MCO/SE shall publish the members' rights and responsibilities from the member bill of rights in the member handbook. CoLTS MCO/SE shall honor the provisions set forth in the member bill of rights.

(2) The CoLTS MCO/SE shall comply with the grievance resolutions process delineated in 8.307.12 NMAC, *Member Grievance Resolution*.

(3) The CoLTS MCO/SE shall provide members or legal guardians with updated information within 30 days of a material change in the CoLTS MCO/SE provider network, procedures for obtaining benefits, the amount, duration or scope of the benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, and information on grievance, appeal and fair hearing procedures.

(4) The CoLTS MCO/SE shall provide members and legal guardians with access to a toll-free hot line for the CoLTS MCO/SE's program for grievance management. The toll-free hot line for grievance management shall include the following features:

(a) does not require a "touch-tone" telephone;

(b) allows communication with members whose primary language is not English or who are hearing impaired; and

(c) is in operation 24 hours per day, seven days per week.

(5) The CoLTS MCO/SE shall provide active and participatory education of members or legal guardians that takes into account the cultural, ethnic and linguistic needs of members in order to assure understanding of the health care program, improve access and enhance the quality of service provided.

(6) The shall protect the confidentiality of member information and records.

(a) The CoLTS MCO/SE shall adopt and implement written confidentiality policies and procedures that conform to federal and state laws and regulations.

(b) The CoLTS MCO/SE's contracts with service providers shall explicitly state expectations about confidentiality of member information and records.

(c) The CoLTS MCO/SE shall afford members or legal guardians the opportunity to approve or deny release by the CoLTS MCO/SE of identifiable personal information to a person or agency outside the CoLTS MCO/SE, except when release is required by law, state regulation, court order, HSD quality standards, or in the case of behavioral health, the collaborative.

(d) The CoLTS MCO/SE shall notify members and legal guardians in a timely manner when information is released in response to a court order.

(e) The CoLTS MCO/SE shall have written policies and procedures to maintain confidential information gathered or learned during the investigation or resolution of a complaint, including a member's status as a complainant.

(f) The CoLTS MCO/SE shall have written policies and procedures to maintain confidentiality of medical records used in quality review, measurement and improvement activities.

(7) When the CoLTS MCO/SE delegates member service activity, the CoLTS MCO/SE shall retain responsibility for documenting CoLTS MCO/SE oversight of the delegated activity.

(8) Policies regarding consent for treatment shall be disseminated annually to service providers within the CoLTS MCO/SE network. The CoLTS MCO/SE shall have written policies regarding the requirement for service providers to abide by federal and state law and New Mexico medicaid policies regarding informed consent specific to:

(a) the treatment of minors;
(b) adults who are in the custody of the state;
(c) adults who are the subject of an active protective services case with CYFD;
(d) children and adolescents who fall under the jurisdiction of CYFD; and
(e) individuals who are unable to exercise rational judgment or give informed consent

consistent with federal and state laws and New Mexico medicaid regulations.

(9) The CoLTS MCO/SE shall have a process to detect, measure and eliminate operational bias or discrimination against members. The CoLTS MCO/SE shall ensure that its service providers and their facilities comply with the Americans with Disabilities Act.

(10) The CoLTS MCO/SE shall develop and implement policies and procedures to allow members to access behavioral health services without going through the PCP. These policies and procedures must afford timely access to behavioral health services.

(11) The CoLTS MCO shall not restrict a member's right to choose a provider of family planning services.

(12) The CoLTS MCO/SE's communication with members shall be responsive to the various populations by demonstrating cultural competence in the materials and services provided to members. The CoLTS MCO/SE shall provide information to its network providers about culturally relevant services and may provide information about alternative treatment options, e.g., American Indian healing practices if available. Information and materials provided by the CoLTS MCO/SE to medicaid members shall be written at a sixth-grade language level and shall be made available in the prevalent population language.

[8.307.8.15 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.16 STANDARDS FOR PREVENTIVE HEALTH SERVICES: The CoLTS MCO shall follow current national standards for preventive health services including behavioral health preventive services. Standards are derived from several sources, including the U.S. preventive services task force, the centers for disease control and prevention; and the American college of obstetricians and gynecologists. Any preventive health guidelines developed by the CoLTS MCO under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to service provider and member. Unless a member refuses and the refusal is documented, the CoLTS MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The CoLTS MCO shall document medical reasons not to perform these services for an individual member. Member refusal is defined to include refusal to consent to and refusal to access services.

A. **Initial assessment:** The CoLTS MCO shall perform an initial assessment of the medicaid member's health service needs within 90 days of the date the member enrolls in the CoLTS MCO. For this purpose, a member is considered enrolled at the lock-in date. This assessment must include a question regarding the member's primary language, spoken and written and sign language, if necessary.

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

C. **Screens:** The CoLTS MCO shall adopt policies which will ensure that, to the extent possible, within six months of enrollment or within six months of a change in screening standards, asymptomatic members receive at least the following preventive screening services.

(1) *Screening for breast cancer*: Females aged 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Screening for cervical cancer*: Female members with a cervix shall receive cytopathology testing starting at the onset of sexual activity, but at least by 21 years of age and every three years thereafter until reaching 65 years of age if prior testing has been consistently normal and the member has been confirmed not to be at high risk. If the member is at high risk, the frequency shall be at least annual.

(3) *Screening for colorectal cancer*: Members aged 50 years and older at normal risk for colorectal cancer shall be screened with annual fecal occult blood testing or sigmoidoscopy or colonoscopy or double contrast barium, at a periodicity determined by the CoLTS MCO.

(4) *Blood pressure measurement*: Members over age 18 shall receive a blood pressure measurement at least every two years.

(5) *Serum cholesterol measurement*: Male members aged 35 and older and female members aged 45 and older who are at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. Adults aged 20 or older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements.

(6) *Screening for obesity*: Members shall receive body weight and height/length measurements with each physical exam. Children shall receive a BMI percentile designation.

(7) *Screening for elevated lead levels*: Members aged 9-15 months (ideally at 12 months) shall receive a blood lead measurement at least once.

(8) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk persons shall be screened or previous screening noted: persons who immigrated from countries in Asia, Africa, Latin America or the Middle East in the preceding five years; persons who have substantial contact with immigrants from those areas; migrant farm workers; and persons who are alcoholic, homeless or injecting drug users. HIV-infected persons shall be screened annually. Persons whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local public health office in their community of residence for contact investigation.

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

(10) *Screening for chlamydia;* All sexually active female members age 25 or younger shall be screened for chlamydia. All female members over age 25 shall be screened for chlamydia if they inconsistently use barrier conception, have more than one sex partner or have had a sexually transmitted disease in the past.

(11) *Screening for type 2 diabetes*: Individuals with one or more of the following risk factors for diabetes shall be screened. Risk factors include a family history of diabetes (parent or sibling with diabetes); obesity (>20% over desired body weight or BMI >27kg/m2); race/ethnicity (e.g. Hispanic, Native American, African American, Asian-Pacific islander); previously identified impaired fasting glucose or impaired glucose tolerance; hypertension (>140/90 mmHg); HDL cholesterol level <35 mg/dl and triglyceride level >250 mg/dl; history of gestational diabetes mellitus (GDM) or delivery of babies over nine lbs.

(12) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, D(Rh) incompatibility, down syndrome, neural tube defects, hemoglobinopathies, vaginal and rectal group B streptococcal infection and screened and counseled for HIV in accordance with the most current recommendations of the American college of obstetricians and gynecologists.

(13) *Newborn screening*: Newborn members shall be screened for those disorders specified in the state of New Mexico metabolic screen.

(14) *Tot-to-teen health checks*: The CoLTS MCO shall operate tot-to-teen mandated early and periodic screening, diagnostic and treatment (EPSDT) services as outlined in 8.320.3 NMAC, *Tot-to-Teen Health Checks*. Within three months of enrollment lock-in, the CoLTS MCO shall ensure that eligible members (up to age 21) are current according to the screening schedule (unless more stringent requirements are specified in these standards). The CoLTS MCO shall encourage PCPs to assess and document for age, height and gender appropriate weight and for BMI percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in children and adolescents.

(15) Members over age 21 must be screened to detect high risk for behavioral health conditions at their first encounter with a PCP after enrollment.

(16) The CoLTS MCO shall require PCPs to refer members, whenever clinically appropriate, to behavioral health providers. The CoLTS MCO/SE shall assist the member with an appropriate behavioral health referral.

D. **Counseling:** The CoLTS MCO shall adopt policies that shall ensure that applicable asymptomatic members are provided counseling on the following topics unless recipient refusal is documented:

(1) prevention of tobacco use;
(2) benefits of physical activity;
(3) benefits of a healthy diet;
(4) prevention of osteoporosis and heart disease in menopausal women citing the advantages and disadvantages of calcium and hormonal supplementation;
(5) prevention of motor vehicle injuries;
(6) prevention of household and recreational injuries;
(7) prevention of dental and periodontal disease;
(8) prevention of HIV infection and other sexually transmitted diseases;
(9) prevention of unintended pregnancies; and
(10) prevention or intervention for obesity or weight issues.

E. **Hot line:** The CoLTS MCO/SE shall provide a toll-free clinical telephone hot line function that includes at least the following services and features:

(1) clinical assessment and triage to evaluate the acuity and severity of the member's symptoms and make the clinically appropriate referral; and
(2) prediagnostic and post-treatment health care decision assistance based on symptoms.

F. **Health information line:** The CoLTS MCO shall provide a toll-free line that includes at least the following services and features:

(1) general health information on topics appropriate to the various medicaid populations, including those with severe and chronic physical and behavioral health conditions; and
(2) preventive/wellness counseling.

G. **Family planning:** The CoLTS MCO must have a family planning policy. This policy must ensure that members of the appropriate age of both sexes who seek family planning services are provided with counseling and treatment, if indicated, as it relates to the following:

(1) methods of contraception; and
(2) HIV and other sexually transmitted diseases and risk reduction practices.

H. **Prenatal care:** The CoLTS MCO shall operate a proactive prenatal care program to promote early initiation and appropriate frequency of prenatal care consistent with the standards of the American college of obstetrics and gynecology. The program shall include at least the following:

(1) educational outreach to all members of childbearing age;
(2) prompt and easy access to obstetrical services, including an office visit with a service provider within three weeks of having a positive pregnancy test (laboratory or home) unless earlier service is clinically indicated;
(3) risk assessment of all pregnant members to identify high-risk cases for special management;
(4) counseling that strongly advises voluntary testing for HIV;
(5) case management services to address the special needs of members who have a high risk pregnancy especially if risk is due to psychosocial factors such as substance abuse or teen pregnancy;
(6) screening for determination of need for a post-partum home visit; and
(7) coordination with other services in support of good prenatal care, including transportation, other community services and referral to an agency that dispenses baby car seats free or at a reduced price.

[8.307.8.16 NMAC - N, 8-1-08; A, 9-1-09; A, 9-30-09]

8.307.8.17 STANDARDS FOR MEDICAL RECORDS:

A. **Standards and policies:** The CoLTS MCO/SE shall require that member medical records be maintained on paper or electronic format. Member medical records shall be maintained timely, and be legible, current, detailed and organized to permit effective and confidential patient service and quality review.

(1) The CoLTS MCO/SE shall have medical record confidentiality policies and procedures in compliance with state and federal guidelines and HIPAA.

(2) The CoLTS MCO/SE shall have medical record documentation standards that are enforced with its CoLTS MCO/SE providers and subcontractors and require that records reflect all aspects of patient care, including ancillary services. The documentation standards shall, at a minimum, require the following:

(a) patient identification information (on each page or electronic file);

(b) personal biographical data (date of birth, sex, race or ethnicity (if available), mailing address, residential address, employer, school, home and work telephone numbers, name and telephone numbers of emergency contacts, marital status, consent forms and guardianship information);

(c) date of data entry and date of encounter;

(d) service provider identification (author of entry);

(e) allergies and adverse reactions to medications;

(f) past medical history for patients seen two or more times;

(g) status of preventive services provided or at least those specified by HSD or its designee, summarized in an auditable form (a single sheet) in the medical record within six months of enrollment;

(h) diagnostic information;

(i) medication history including what has been effective and what has not, and why;

(j) identification of current problems;

(k) history of smoking, alcohol use and substance abuse for members 12 years of age or older;

(l) reports of consultations and referrals;

(m) reports of emergency services, to the extent possible;

(n) advance directive for adults; and

(o) record legibility to at least a peer of the author.

(3) For behavioral health patients, documentation shall include all elements listed above in addition to the following:

(a) a mental status evaluation that documents affect, speech, mood, thought content, judgment, insight, concentration, memory and impulse control;

(b) DSM-IV diagnosis consistent with the history, mental status examination or other assessment data;

(c) a treatment plan consistent with diagnosis that has objective and measurable goals and time frames for goal attainment or problem resolution;

(d) documentation of progress toward attainment of the goal; and

(e) preventive services such as relapse prevention and stress management.

(4) The CoLTS MCO/SE standards for a member's medical record shall include the following minimum detail for individual clinical encounters:

(a) history (and physical examination) for presenting complaints containing relevant psychological and social conditions affecting the patient's behavioral health, including mental health (psychiatric) and substance abuse status;

(b) plan of treatment;

(c) diagnostic tests and the results;

(d) drugs prescribed, including the strength, amount, directions for use and refills;

(e) therapies and other prescribed regimens and the results;

(f) follow-up plans and directions (such as, time for return visit, symptoms that shall prompt a return visit);

(g) consultations and referrals and the results; and

(h) any other significant aspect of the member's physical or behavioral health services.

B. **Review of records:** The CoLTS MCO/SE shall have a process to systematically review service provider medical records to ensure compliance with the medical record standards. The CoLTS MCO/SE shall institute improvement actions when standards are not met.

(1) The EQRO shall conduct reviews of a representative sample of medical records from the CoLTS MCO's primary care providers, obstetricians, and gynecologists.

(2) The CoLTS MCO/SE shall have a mechanism to assess the effectiveness of organization-wide and practice-site compliance with the CoLTS MCO/SE's established medical record standards and goals.

C. **Access to records:** The CoLTS MCO/SE shall provide HSD or its designee appropriate access to service provider medical records.

(1) The CoLTS MCO shall ensure that the PCP maintains a primary medical record for each member, which contains sufficient medical information from all service providers involved in the member's services, to ensure continuity of services. The CoLTS MCO shall ensure that service providers involved in the member's services have access to the member's primary medical record, including the SE, when necessary.

(2) The CoLTS MCO/SE shall include provisions in its contracts with service providers for appropriate access to the CoLTS MCO/SE's members' medical records for purposes of in-state quality reviews conducted by HSD or its designee, and for making medical records available to service providers, including behavioral health, for each clinical encounter.

(3) The CoLTS MCO shall have a policy that ensures the confidential transfer of medical and dental information when a primary medical or dental provider leaves the CoLTS MCO to another CoLTS MCO.

(4) The SE shall have a policy that ensures the confidential transfer of behavioral health information from one practitioner to another when a provider leaves the SE network or when the member changes behavioral health provider or practitioner.

(5) The CoLTS MCO/SE shall forward health information from the provider's medical records to HSD or its designee, as requested.

[8.307.8.17 NMAC - N, 8-1-08; A, 9-1-09; A, 9-30-09]

8.307.8.18 STANDARDS FOR ACCESS:

A. **Ensure access:** The CoLTS MCO/SE shall establish and follow protocols to ensure the accessibility, availability and referral to service providers for each medically necessary service. The CoLTS MCO/SE shall provide access to the full array of covered services within the benefit package, if a service is unavailable based on the access guidelines, a service equal to or higher than shall be offered.

B. **Access to urgent and emergency services:** Services for emergency conditions provided by physical health providers, including emergency transportation, urgent conditions, and post-stabilization services shall be covered by the CoLTS MCO only within the United States for both physical and behavioral health. The SE shall coordinate all behavioral health transportation with the member's respective CoLTS MCO. An urgent condition exists when a member manifests acute symptoms and signs that, by reasonable medical judgment, represent a condition of sufficient severity that the absence of medical attention within 24 hours could reasonably result in an emergency condition. Serious impairment of biopsychosocial functioning, imminent out-of-home placement for children and adolescents or serious jeopardy to the behavioral health of the member are considered urgent conditions. An emergency condition exists when a member manifests acute symptoms and signs that, by reasonable lay person judgment, represent a condition of sufficient severity that the absence of immediate medical attention, including behavioral health, could reasonably result in death, serious impairment of bodily function or major organ or serious jeopardy to the overall health of the member. Post-stabilization services means covered services related to an emergency medical or behavioral health condition, that are provided after the member is stabilized in order to maintain the stabilized condition and may include improving or resolving the member's condition.

(1) The CoLTS MCO/SE shall ensure that there is no clinically significant delay caused by the CoLTS MCO/SE's utilization control measures. Prior authorization is not required for emergency services in or out of the CoLTS MCO/SE network, and all emergency services shall be reimbursed at the medicaid fee-for-service rate. The CoLTS MCO/SE shall not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical or behavioral health condition under the prudent lay person standard, turned out to be non-emergency in nature.

(2) The CoLTS MCO/SE shall ensure that the member has the right to use any hospital or other licensed emergency setting for emergency services, regardless of whether the service provider is contracted with the CoLTS MCO/SE.

(3) The CoLTS MCO/SE shall ensure that members have access to the nearest appropriately designated trauma center according to established EMS triage and transportation protocols.

C. **Primary care provider availability:** The CoLTS MCO shall follow a process that ensures a sufficient number of primary care providers are available to members to allow the members a reasonable choice among providers.

(1) The CoLTS MCO shall have at least one primary care provider available per 1,500 members and no more than 1,500 members assigned to a single provider unless approved by HSD or its designee.

(2) The minimum number of primary care providers from which to choose and the distances to those providers shall vary by county based on whether the county is urban, rural or frontier. 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 that are not urban or frontier. The standards are as follows:

(a) 90 percent of urban residents shall travel no farther than 30 miles;

(b) 90 percent of rural residents shall travel no farther than 45 miles; and

(c) 90 percent of frontier residents shall travel no farther than 60 miles.

D. **Pharmacy provider availability:** The CoLTS MCO/SE shall ensure that a sufficient number of pharmacy providers are available to members. The CoLTS MCO/SE shall ensure that pharmacy services meet geographic access standards based on the member's county of residence. The access standards are as follows:

(1) 90 percent of urban residents shall travel no farther than 30 miles;

(2) 90 percent of rural residents shall travel no farther than 45 miles; and

(3) 90 percent of frontier residents shall travel no farther than 60 miles.

E. **Access to health care services:** The CoLTS MCO shall ensure that there are a sufficient number of PCPs and dentists available to members to allow members a reasonable choice. The SE shall ensure that there are a sufficient number of behavioral health providers, based on the least restrictive, medically necessary needs of its members, available statewide to members to allow members a reasonable choice.

(1) The CoLTS MCO shall report to HSD or its designee all service provider groups, health centers and individual physician practices and sites in their network that are not accepting new medicaid members.

(2) CoLTS MCO only: For routine, asymptomatic, member-initiated, outpatient appointments for primary medical services, the request-to-appointment time shall be no more than 30 days, unless the member requests a later time.

(3) CoLTS MCO only: For routine asymptomatic member-initiated dental appointments, the request to appointment time shall be consistent with community norms for dental appointments.

(4) CoLTS MCO only: For routine, symptomatic, member-initiated, outpatient appointments for nonurgent primary medical and dental services, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(5) SE only: For non urgent behavioral health care, the request-to-appointment time shall be no more than 14 days, unless the member requests a later time.

(6) CoLTS MCO/SE: Primary medical, dental and behavioral health service outpatient appointments for urgent conditions shall be available within 24 hours.

(7) CoLTS MCO only: For specialty outpatient referral and consultation appointments, excluding behavioral health, which is addressed in (5) above, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 days, unless the member requests a later time.

(8) CoLTS MCO only: For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 days, unless the member requests a later time.

(9) CoLTS MCO only: For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a "walk-in" rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need.

(10) CoLTS MCO only: For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours.

(11) CoLTS MCO/SE: The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes. A prescription phoned in by a service provider shall be filled within 90 minutes.

(12) CoLTS MCO/SE: The timing of scheduled follow-up outpatient visits with service providers shall be consistent with the clinical need.

(13) The CoLTS MCO/SE shall ensure that a medically necessary pharmaceutical agent is provided in a clinically timely manner.

(14) The CoLTS MCO/SE's preferred drug list (PDL) shall follow HSD guidelines in Subsection O of 8.307.7.11 NMAC, *services included in the salud! benefit package, pharmacy services*.

(15) The CoLTS MCO shall approve or deny a request for new durable medical equipment (DME) or for repairs to existing DME owned or rented by the member within seven working days of the request date.

(a) All new customized or made-to-measure DME or customized modifications to existing DME owned or rented by the member shall be delivered to the member within 150 days of the request date.

(b) All standard DME shall be delivered within 24 hours of the request, if needed on an urgent basis.

(c) All standard DME not needed on an urgent basis shall be delivered within a time frame consistent with clinical need.

(d) All DME repairs or non-customized modifications shall be delivered within 60 days of the request date.

(e) The CoLTS MCO shall have an emergency response plan for non-customized DME needed on an emergent basis.

(16) The CoLTS MCO shall approve or deny a request for prescribed medical supplies within seven working days of the request date. The CoLTS MCO shall ensure that:

(a) members can access prescribed medical supplies within 24 hours when needed on an urgent basis;

(b) members can access routine medical supplies within a time frame consistent with the clinical need;

(c) subject to any requirements to procure a physician's order to provide supplies to the member, members utilizing medical supplies on an ongoing basis shall submit to the CoLTS MCO lists of needed supplies monthly; and the CoLTS MCO or its subcontractor shall contact the member if the requested supplies cannot be delivered in the time frame expected and make other delivery arrangements consistent with clinical need.

(17) The CoLTS MCO shall ensure that members and members' families receive proper instruction on the use of DME and medical supplies provided by the CoLTS MCO/SE or its subcontractor.

F. **Access to transportation services:** The CoLTS MCO shall provide the transportation benefit for medically necessary physical and behavioral health. The CoLTS MCO MCO shall coordinate behavioral health transportation services with the SE. The CoLTS MCO shall have sufficient transportation service providers available to meet the needs of members, including an appropriate number of handivans available for members who are wheelchair or ventilator dependant or have other equipment needs. The CoLTS MCO shall develop and implement policies and procedures to ensure that:

(1) transportation arranged is appropriate for the member's clinical condition;

(2) the history of services is available at the time services are requested to expedite appropriate arrangements;

(3) CPR-certified drivers are available to transport members consistent with clinical need;

(4) the transportation type is clinically appropriate, including access to non-emergency ground ambulance carriers;

(5) members can access and receive authorization for medically necessary transportation services under certain unusual circumstances without advance notification; and

(6) minors are accompanied by a parent or legal guardian as indicated to provide safe transportation.

G. **Use of technology:** The CoLTS MCO/SE is encouraged to use state-of-the-art technology, such as telemedicine, to ensure access and availability of services statewide.

[8.307.8.18 NMAC - N, 8-1-08; A, 9-1-09]

8.307.8.19 DELEGATION: Delegation is a process whereby a CoLTS MCO/SE gives another entity the authority to perform certain functions on its behalf. The CoLTS MCO/SE is fully accountable for all predelegation and delegation activities and decisions made. The CoLTS MCO/SE shall document its oversight of the delegated activity. The SE may assign, transfer, or delegate to a subcontractor key management functions including, but not limited to, care coordination and universal credentialing with the explicit written approval of HSD.

A. A mutually agreed upon document between CoLTS MCO/SE and the delegated entity shall describe:

(1) the responsibilities of the CoLTS MCO/SE and the entity to which the activity is delegated;

(2) the delegated activity;

(3) the frequency and method of reporting to the CoLTS MCO/SE;

(4) the process by which the CoLTS MCO/SE evaluates the delegated entity's performance; and

(5) the remedies up to, and including, revocation of the delegation, available to the CoLTS MCO/SE if the delegated entity does not fulfill its obligations.

B. The CoLTS MCO/SE shall document evidence that the CoLTS MCO/SE:

(1) evaluated the delegated entity's capacity to perform the delegated activities prior to delegation;

(2) evaluates regular reports and proactively identifies opportunities for improvement; and

(3) evaluates at least semi-annually the delegated entity's activities in accordance with the CoLTS MCO/SE's expectations and HSD's standards.

[8.307.8.19 NMAC - N, 8-1-08; A, 9-1-09]

HISTORY OF 8.307.8 NMAC: [RESERVED]