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TITLE 8 SOCIAL SERVICES
CHAPTER 305 MEDICAID MANAGED CARE
PART 3 CONTRACT MANAGEMENT

8.305.3.1 ISSUING AGENCY: Human Services Department
[8.305.3.1 NMAC - Rp 8.305.3.1 NMAC, 7-1-04]

8.305.3.2 SCOPE: This rule applies to the general public.
[8.305.3.2 NMAC - Rp 8.305.3.2 NMAC, 7-1-04]

8.305.3.3 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. See NMSA 1978 Section 27-2-12 et. seq.
[8.305.3.3 NMAC - Rp 8.305.3.3 NMAC, 7-1-04]

8.305.3.4 DURATION: Permanent
[8.305.3.4 NMAC - Rp 8.305.3.4 NMAC, 7-1-04]

8.305.3.5 EFFECTIVE DATE: July 1, 2004, unless a later date is cited at the end of a section.
[8.305.3.5 NMAC - Rp 8.305.3.5 NMAC, 7-1-04]

8.305.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid managed care program.
[8.305.3.6 NMAC - Rp 8.305.3.6 NMAC, 7-1-04]

8.305.3.7 DEFINITIONS: See 8.305.1.7 NMAC.
[8.305.3.7 NMAC - Rp 8.305.3.7 NMAC, 7-1-04]

8.305.3.8 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 life of their communities.
[8.305.3.8 NMAC - Rp 8.305.3.8 NMAC, 7-1-04; A, 7-1-09]

8.305.3.9 ELIGIBLE MANAGED CARE ORGANIZATIONS (MCO) AND THE BEHAVIORAL HEALTH SINGLE STATEWIDE ENTITY (SE): The human services department (HSD) shall award risk-based contracts to MCOs and a contract to the single SE with statutory authority to assume risk and enter into prepaid capitation agreements, which meet applicable requirements and standards delineated under state and federal law including Title V of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

A. **Procurement process:** HSD shall award risk-based contracts to MCOs/SE using a competitive procurement process that conforms to the terms of the New Mexico Procurement Code. Offerors must submit their responses to the request for proposal in conformity with the requirements specified in the request for proposal.]

B. **Contract issuance:** The risk-based contracts shall be awarded for at least a two-year period. Contracts are issued to offerors meeting requirements specified under the terms of the managed care contract.
[8.305.3.9 NMAC - Rp 8.305.3.9 NMAC, 7-1-04; A, 7-1-05; A, 7-1-09]

8.305.3.10 CONTRACT MANAGEMENT: HSD is responsible for management of the medicaid contracts issued to MCOs/SE. HSD shall provide the oversight and administrative functions to ensure MCO/SE compliance with the terms of the medicaid contract. HSD shall provide oversight of the SE contract as it relates to medicaid behavioral health services, providers and members.

A. **General contract requirements:** The MCO/SE shall meet all specified terms of the medicaid contract with HSD as it relates to medicaid members and services and the Health Insurance Portability and Accountability Act (HIPAA). This includes, but is not limited to, insuring confidentiality as it relates to medical records and any other health and enrollment information that identifies a particular member. The MCO/SE shall be

held harmless in conversion to HIPAA electronic transmission formats when delays are the result of implementation issues at HSD.

B. Subcontracting requirements: The MCO/SE may subcontract to a qualified individual or organization the provision of any service defined in the benefit package or other required MCO/SE functions with HSD's approval. The MCO/SE shall submit boilerplate contract language and sample contracts for various types of subcontracts for HSD's approval. Any substantive changes to contract templates shall be approved by HSD prior to issuance. 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.

(1) **Credentialing requirements:** The MCO/SE shall maintain policies and procedures for verifying that the credentials of its providers and subcontractors meet applicable standards. The MCO/SE shall assure the prospective subcontractor's ability to perform the activities to be delegated.

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

(3) **Minimum requirements (MCO/SE):**

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

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

(c) subcontracts shall include the frequency of reporting (if applicable) to the MCO/SE and the process by which the MCO/SE evaluates the subcontractor;

(d) subcontracts shall identify the services to be performed by the subcontractor and the services to be performed under other subcontracts; subcontracts must describe how members access services provided under the subcontract;

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

(f) subcontractors shall maintain records relating to services provided to members for 10 years;

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

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

(i) subcontracts shall include a provision for the subcontractor to release to the MCO/SE any information necessary to perform any of its obligations;

(j) subcontractors shall accept payment from the MCO/SE for any services included in the benefit package and cannot request payment from HSD for services performed under the subcontract;

(k) if subcontracts include primary care, provisions for compliance with PCP requirements delineated in the MCO contract with HSD apply;

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

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

(n) subcontracts shall not prohibit a provider or other subcontractor from entering into a contractual relationship with another MCO (MCO only);

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

(p) subcontracts shall not contain any gag order provisions nor sanctions against providers who assist members in accessing the grievance process or otherwise act to protect members' interests;

(q) subcontracts shall specify the time frame for submission of encounter data to the MCO/SE;

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

(s) subcontracts shall include a provision requiring subcontractors to perform criminal background checks, as required by law, for all individuals providing services;

(t) (MCO only) subcontracts shall include a provision requiring providers to submit claims electronically; transportation, meals, lodging, low volume or low dollar providers may have this requirement waived; and

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

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

C. **Provider incentive plans:** The MCO/SE shall ensure that direct or indirect incentives offered in the subcontract shall not serve as an inducement to reduce or limit medically necessary services to members. [8.305.3.10 NMAC - Rp 8.305.3.10 NMAC, 7-1-04; A, 7-1-05; A, 9-1-06; A, 7-1-07; A, 7-1-08; A, 7-1-09]

8.305.3.11 ORGANIZATIONAL REQUIREMENTS:

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

- (1) current written charts of organization or other written plans identifying organizational lines of accountability;
- (2) articles of incorporation, bylaws, partnership agreements, or similar documents that describe the MCO's/SE's mission, organizational structure, board and committee composition, mechanisms to select officers and directors and board and public meeting schedules; and
- (3) documents describing the MCO's/SE's relationship to parent affiliated and related business entities including, but not limited to, subsidiaries, joint ventures or sister corporations.

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

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

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

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

(4) **Financial requirements:** The MCO/SE shall meet minimum requirements delineated by federal and state law with respect to solvency and performance guarantees for the duration of the contract. In addition, the MCO/SE shall meet additional financial requirements specified in the contract.

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

(6) **Consumer advisory board:** The MCOs and the SE shall establish their respective consumer advisory board that includes regional representation of consumers, family members, advocates and providers. The MCO and the SE consumer advisory boards shall interface and collaborate with one another as appropriate. If the formation of a separate SCI consumer advisory board is deemed impractical because of enrollment of less than 2,500 members, the MCO shall include at least three SCI members in the Salud! consumer advisory board meetings.

(a) The MCO consumer advisory board members shall serve to advise the MCO on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. The SE consumer advisory board members shall serve to advise the SE on issues concerning service delivery and quality of service, the member bill of rights and member responsibilities, resolution of member

grievances and the needs of groups represented by board member as they pertain to medicaid, including managed care. The MCO/SE shall hold quarterly, centrally located meetings every year. The attendance roster and minutes shall be made available to HSD on request. The MCO/SE shall advise HSD 10 days in advance of meetings to be held. HSD shall attend and observe the MCO's consumer advisory board meetings at their discretion. HSD shall attend and observe the SE's consumer advisory board meetings at its discretion.

(b) The SE shall attend at least two statewide consumer driven or hosted meetings per year, of the SE's choosing, that focus on consumer issues and needs, to ensure that members' concerns are heard and addressed. The MCO will hold at least two additional statewide consumer advisory board meetings each contract year that focus on consumer issues to help ensure that consumer issues and concerns are heard and addressed. Attendance rosters and minutes for these two statewide meetings shall be made available to HSD.

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

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

- (a) require plans of correction;
- (b) impose directed plans of correction;
- (c) impose monetary penalties or sanctions to the extent authorized by federal or state law:
 - (i) HSD retains the right to apply progressively stricter sanctions against the MCO/SE, including an assessment of a monetary penalty against the MCO/SE, for failure to perform in any contract area;
 - (ii) unless otherwise required by law, the level of sanctions shall be based on the frequency or pattern of conduct, or the severity or degree of harm posed to or incurred by members or the integrity of the medicaid program;
 - (iii) a monetary penalty, depending upon the severity of the infraction; penalty assessments shall range up to five percent of the MCO's/SE's medicaid capitation payment for each month in which the penalty is assessed;
 - (iv) any withholding of capitation payments in the form of a penalty assessment does not constitute just cause for the MCO/SE to interrupt services provided to members; and
 - (v) all administrative, contractual or legal remedies available to HSD shall be employed in the event that the MCO/SE violates or breaches the terms of the contract;
- (d) impose other civil or administrative monetary penalties and fines under the following guidelines:
 - (i) a maximum of \$25,000.00 for each of the following determinations: failure to provide service; misrepresentation or false statements to members, potential members, or health care providers; failure to comply with physician incentive plan requirements; and marketing violations;
 - (ii) a maximum of \$100,000.00 for each of the following determinations: discrimination or misrepresentation or false statements to HSD or CMS;
 - (iii) a maximum of \$15,000.00 for each member HSD determines was not enrolled, or reenrolled, or enrollment was terminated because of a discriminatory practice; this is subject to an overall limit of \$100,000.00 under (ii) above;
 - (iv) a maximum of \$25,000.00 or double the amount of the excess charges, whichever is greater, for premiums or charges in excess of the amount permitted under the medicaid program; the state must deduct from the penalty the amount of overcharge and return it to the affected enrollees;
- (e) adjust automatic assignment formula;
- (f) rescind marketing consent;
- (g) suspend new enrollment, including default enrollment after the effective date of the sanction;
- (h) appoint a state monitor, the cost of which shall be borne by the MCO/SE;
- (i) deny payment;
- (j) assess actual damages;
- (k) assess liquidated damages;
- (l) remove members with third party coverage from enrollment with the MCO/SE;
- (m) allow members to terminate enrollment;
- (n) suspend agreement;

- (o) terminate MCO/SE contract;
- (p) apply other sanctions and remedies specified by HSD; and
- (q) impose temporary management only if it finds, through on-site survey, enrollee complaints, or any other means that;

- (i) there is continued egregious behavior by the MCO/SE, including but not limited to, behavior that is described in Subparagraph (d) above, or that is contrary to any requirements of 42 USC Sections 1396b(m) or 1396u-2; or

- (ii) there is substantial risk to member's health; or
- (iii) the sanction is necessary to ensure the health and safety of the MCO's/SE's members while improvement is made to remedy violations made under Subparagraph (d) above; or until there is orderly termination or reorganization of the MCO/SE;

- (iv) HSD shall not delay the imposition of temporary management to provide a hearing before imposing this sanction; HSD shall not terminate temporary management until it determines that the MCO/SE can ensure that the sanction behavior will not re-occur; refer to state and federal regulations for due process procedures.

[8.305.3.11 NMAC - Rp 8.305.3.11 NMAC, 7-1-04; A, 7-1-05; A, 7-1-07; A, 7-1-08; A, 7-1-09]

HISTORY OF 8.305.3 NMAC: The material in this part was derived from that previously filed with the Commission of Public Records - State Records Center and Archives:
8 NMAC 4.MAD.606.2, Managed Care Policies, Contract Management, 6-19-97.

History of Repealed Material:

8 NMAC 4.MAD.606.2, Managed Care Policies, Contract Management - Repealed, 7-1-01.
8.305.3 NMAC, Medicaid Managed Care, Contract Management - Repealed 7-1-04.