This is an amendment to 8.308.9 NMAC, Sections 7, 8, 11, 13, 15 - 17, 19, 22, 23 and 25, effective 4/5/2022.

8.308.9.7 DEFINITIONS:

A. Alternative benefits plan services with limitations (ABP): The medical assistance division (MAD) category of eligibility "other adults" has an alternative benefit plan (ABP). The HSD contracted managed care organization (MCO) covers ABP specific services for an ABP member. Services are made available through MAD under a benefit plan similar to services provided by commercial insurance plans. ABP benefits include preventive services and treatment services. An ABP member has limitations on specific benefits; and does not have all MCO medicaid benefits available. All early and periodic screening, diagnosis and treatment (EPSDT) program services are available to an ABP member under 21 years. ABP services for an ABP member under the age of 21 years are not subject to the duration, frequency, and annual or lifetime benefit limitations that are applied to an ABP eligible recipient 21 years of age and older. A MCO ABP contracted provider and an ABP member have rights and responsibilities as described in Title 8 Chapter 308 NMAC, Social Services.

B. Alternative benefits plan general benefits for ABP exempt member (ABP exempt): An ABP member who self-declares [~~he or she has~~] they have a qualifying condition is evaluated by the MCO's utilization management for determination if [~~he or she meets~~] they meet the qualifying condition. An ABP exempt member utilizes [~~his or her~~] their benefits described in 8.308.9 NMAC and in 8.308.12 NMAC.

C. Early childhood home visiting program: A program that uses home visiting as a primary service delivery strategy and offers services on a voluntary basis to eligible pregnant [~~women~~] individuals and their children from birth up to kindergarten entry, according to the program standard.

D. Evidence-based, early childhood home visiting program: A home visiting program that is recognized by the U.S. department of health & human services maternal, infant, and early childhood home visiting (MIECHV) project and:

(1) is grounded in relevant, empirically-based best practice and knowledge that:

(a) is linked to and measures the following outcomes:

(i) babies that are born healthy;

(ii) children that are nurtured by their parents and caregivers;

(iii) children that are physically and mentally healthy;

(iv) children that are ready for school;

(v) children and families that are safe; and

(vi) families that are connected to formal and informal supports in their communities;

(b) has comprehensive home visiting standards that ensure high-quality service delivery and continuous quality improvement; and

(c) has demonstrated significant, sustained positive outcomes;

(2) follows program standards that specify the purpose, outcomes, duration and frequency of services that constitute the program;

(3) follows the curriculum of an evidence-based home visiting model;

(4) employs well-trained and competent staff and provides continual professional supervision and development relevant to the specific program and model being delivered;

(5) demonstrates strong links to other community-based services;

(6) operates within an organization that ensures compliance with home visiting standards;

(7) continually evaluates performance to ensure fidelity to the program standards;

(8) collects data on program activities and program outcomes; and

(9) is culturally and linguistically appropriate.

[8.308.9.7 NMAC - Rp, 8.308.9.7 NMAC, 5/1/2018; A, 1/1/2019; A, 4/5/2022]

8.308.9.8 [~~RESERVED~~] MISSION: To transform lives. Working with our partners, we design and deliver innovative, high quality health and human services that improve the security and promote independence for New Mexicans in their communities.

[8.308.9.8 NMAC - Rp, 8.308.9.8 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.11 GENERAL PROGRAM DESCRIPTION:

A. The MCO shall provide medically necessary services consistent with the following:

(1) a determination that a health care service is medically necessary does not mean that the health care service is a covered benefit; benefits are to be determined by HSD;

(2) in making the determination of medical necessity of a covered service the MCO shall do so by:

(a) evaluating the member's physical and behavioral health information provided by a qualified professional who has personally evaluated the member within [~~his or her~~] their scope of practice; who has taken into consideration the member's clinical history, including the impact of previous treatment and service interventions and who has consulted with other qualified health care professionals with applicable specialty training, as appropriate;

(b) considering the views and choices of the member or [~~his or her~~] their authorized representative regarding the proposed covered service as provided by the clinician or through independent verification of those views; and

(c) considering the services being provided concurrently by other service delivery systems;

(3) not denying physical, behavioral health and long-term care services solely because the member has a poor prognosis; medically necessary services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible member solely because of his or her diagnosis, type of illness or condition;

(4) governing decisions regarding benefit coverage for a member under 21 years of age by the EPSDT program coverage rule to the extent they are applicable; and

(5) making services available 24 hours, seven days a week, when medically necessary and are a covered benefit.

B. The MCO shall meet all HSD requirements related to the anti-gag requirement. The MCO shall meet all HSD requirements related to advance directives. This includes but is not limited to:

(1) providing a member or his or her authorized representative with written information on advance directives that include a description of applicable state and federal law and regulation, the MCO's policy respecting the implementation of the right to have an advance directive, and that complaints concerning noncompliance with advance directive requirements may be filed with HSD; the information must reflect changes in federal and state statute, regulation or rule as soon as possible, but no later than 90 calendar days after the effective date of such a change;

(2) honoring advance directives within its UM protocols; and

(3) ensuring that a member is offered the opportunity to prepare an advance directive and that, upon request, the MCO provides assistance in the process.

C. The MCO shall allow second opinions: A member or [~~his or her~~] their authorized representative shall have the right to seek a second opinion from a qualified health care professional within [~~his or her~~] their MCO's network, or the MCO 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 his or her authorized representative needs additional information regarding recommended treatment or believes the provider is not authorizing requested care.

D. The MCO shall meet all care coordination requirement set forth in 8.308.10 NMAC, Care Coordination.

E. The MCO shall meet all behavioral health parity requirements as set forth in CFR 42, Chapter IV, subchapter C, 438.905 - Parity requirements.

[8.308.9.11 NMAC - Rp, 8.308.9.11 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.13 SPECIFIC CASE MANAGEMENT PROGRAMS: The benefit package includes case management services necessary to meet an identified service need of a member. The following are specific case management programs available when a member meets the requirements of a specific service.

A. Case management services for adults with developmental disabilities: Case management services are provided to a member 21 years of age and older who is developmentally disabled as detailed in 8.326.2 NMAC.

B. Case management services for pregnant [~~women~~] individuals and their infants: Case management services are provided to a member who is pregnant up to 60 calendar days following the end of the month of the delivery as detailed in 8.326.3 NMAC.

C. Case management services for traumatically brain injured adults: Case management services are provided to a member 21 years of age and older who is traumatically brain injured as detailed in 8.326.5 NMAC.

D. Case management services for children up to the age of three: Case management services for a member up to the age of three years who is medically at-risk due to family conditions and who does not have a developmental delay as detailed in 8.326.6 NMAC.

E. Case management services for the medically at risk (EPSDT): Case management services for a member under 21 years of age who is medically at-risk for a physical or behavioral health condition as detailed in 8.320.2 NMAC.

[8.308.9.13 NMAC - Rp, 8.308.9.13 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.15 EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) SERVICES: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Part 441, Subpart B) provided by a primary care provider (PCP) as detailed in 8.320.2 NMAC. The MCO shall provide access to early intervention programs and services for a member identified in an EPSDT screen as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder. Unless otherwise specified in a service rule, EPSDT services are for a member under 21 years of age. For detailed description of each service, see 8.320.2 NMAC. EPSDT behavioral health services are included in 8.308.9.19 NMAC.

A. EPSDT nutritional counseling and services: The benefit package includes nutritional services furnished to a pregnant member and a member under 21 years of age as detailed in 8.310.2 NMAC.

B. EPSDT personal care: The benefit package includes personal care services for a member.

C. EPSDT private duty nursing: The benefit package includes private duty nursing for a member and the services shall be delivered in either his or her home or school setting.

D. EPSDT rehabilitation services: A member under 21 years of age who is eligible for home and community based waiver services receives medically necessary rehabilitation services through the EPSDT program; see 8.320.2 NMAC for a detailed description. The home and community-based waiver program provides rehabilitation services only for the purpose of community integration.

E. Services provided in schools: The benefit package includes services to a member provided in a school, excluding those specified in [~~his or her~~] their individual education plan (IEP) or the individualized family service plan (IFSP); see 8.320.6 NMAC.

F. Tot-to-teen health checks:

(1) The MCO shall adhere to the MAD periodicity schedule and ensure that each eligible member receives age-appropriate EPSDT screens (tot-to-teen health checks), referrals, and appropriate services and follow-up care. See 8.320.2 NMAC for detailed description of the benefits. The services include, but are not limited to:

(a) education of and outreach to a member or the member's family regarding the importance of regular screens and health checks;

(b) development of a proactive approach to ensure that the member receives the services;

(c) facilitation of appropriate coordination with school-based providers;

(d) development of a systematic communication process with MCO network providers regarding screens and treatment coordination;

(e) processes to document, measure and assure compliance with MAD's periodicity schedule; and

(f) development of a proactive process to insure the appropriate follow-up evaluation, referral and treatment, including early intervention for developmental delay, vision and hearing screening, dental examinations and immunizations.

(2) The MCO will facilitate appropriate referral for possible or identified behavioral health conditions. See 8.321.2 NMAC for EPSDT behavioral health services descriptions.

[8.308.9.15 NMAC - Rp, 8.308.9.15 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.16 REPRODUCTIVE HEALTH SERVICES: The benefit package includes reproductive health services as detailed in 8.310.2 NMAC. The MCO shall implement written policies and procedures approved by HSD which define how a member is educated about his or her rights to family planning services, freedom of choice, to include access to non-contract providers, and methods for accessing family planning services.

A. The family planning policy shall ensure that a member of the appropriate age of both sexes who seeks family planning services shall be provided with counseling pertaining to the following:

(1) human immunodeficiency virus (HIV) and other sexually transmitted diseases and risk reduction practices; and

(2) birth control pills and devices including plan B and long acting reversible contraception.

B. The MCO shall provide a member with sufficient information to allow [~~him or her~~] them to make informed choices including the following:

(1) types of family planning services available;

(2) the member's right to access these services in a timely and confidential manner;

(3) freedom to choose a qualified family planning provider who participates in the MCO network or from a provider who does not participate in the member's MCO network; and

(4) if a member chooses to receive family planning services from a non-contracted provider, the member shall be encouraged to exchange medical information between the PCP and the non-contracted provider for better coordination of care.

C. Pregnancy termination procedures: The benefit package includes services for the termination of a pregnancy as detailed in 8.310.2 NMAC. Medically necessary pregnancy terminations which do not meet the requirements of 42 CFR 441.202 are excluded from the capitation payment made to the MCO and shall be reimbursed solely from state funds pursuant to the provisions of 8.310.2 NMAC.

[8.308.9.16 NMAC - Rp, 8.308.9.16 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.17 PREVENTIVE PHYSICAL HEALTH SERVICES: The 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 MCO under these standards shall be adopted and reviewed at least every two years, updated when appropriate and disseminated to its practitioners and members. Unless a member refuses and the refusal is documented, the MCO shall provide the following preventive health services or screens or document that the services (with the results) were provided by other means. The 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 care.

A. Initial assessment: The MCO shall conduct a health risk assessment (HRA), per HSD guidelines and processes, for the purpose of obtaining basic health and demographic information about the member, assisting the MCO in determining the need for a comprehensive needs assessment (CNA) for care coordination level assignment.

B. Family planning: The MCO must have a family planning policy. This policy must ensure that a member of the appropriate age of both sexes who seeks family planning services is 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.

C. Guidance: The MCO shall adopt policies that shall ensure that an applicable asymptomatic member is provided guidance on the following topics unless the member's 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 a menopausal member 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 an unintended pregnancy; and

(10) prevention or intervention for obesity or weight issues.

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

E. Nurse advice line: The MCO shall provide a toll-free clinical telephone nurse advice 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) pre-diagnostic and post-treatment health care decision assistance based on the member's symptoms.

F. Prenatal care: The 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 a member of childbearing age;

(2) prompt and easy access to obstetrical care, including an office visit with a practitioner within three weeks of having a positive pregnancy test (laboratory or home) unless earlier care is clinically indicated;

(3) risk assessment of a pregnant member to identify high-risk cases for special management;

(4) counseling which strongly advises voluntary testing for HIV;

(5) case management services to address the special needs of a member who has 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;

(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; and

(8) referral to a home visiting pilot program for eligible pregnant [~~women~~] individuals and children residing in the HSD-designated counties for services as outlined at 8.308.9.23 NMAC.

G. Screens: The 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, each asymptomatic member receives at least the following preventive screening services listed below.

(1) *Screening for breast cancer*: A female member between the ages of 40-69 years shall be screened every one to two years by mammography alone or by mammography and annual clinical breast examination.

(2) *Blood pressure measurement*: A member 18 years of age or older shall receive a blood pressure measurement at least every two years.

(3) *Screening for cervical cancer*: A female member 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 when 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.

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

(5) *Screening for colorectal cancer*: A member 50 years of age and older, who is 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 MCO.

(6) *EPSDT screening for elevated blood lead levels*: A risk assessment for elevated blood lead levels shall be performed beginning at six months and repeated at nine months of age. A member shall receive a blood lead measurement at 12 months and 24 months of age. A member between the ages of three and six years, for whom no previous test exists, should also be tested, and screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(7) *EPSDT newborn screening*: A newborn member shall be screened for those disorders specified in the state of New Mexico metabolic screen and any screenings shall be done in accordance with the most current recommendations of the American academy of pediatrics.

(8) *Screening for obesity*: A member shall receive body weight, height and length measurements with each physical exam. A member under 21 years of age shall receive a BMI percentile designation.

(9) *Prenatal screening*: All pregnant members shall be screened for preeclampsia, Rh (D) 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.

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

(11) *Screening for tuberculosis*: Routine tuberculin skin testing shall not be required for all members. The following high-risk members shall be screened or previous screenings noted:

(a) a member who has immigrated from countries in Asia, Africa, Latin America or the middle east in the preceding five years;

(b) a member who has substantial contact with immigrants from those areas; a member who is a migrant farm worker;

(c) a member who is an alcoholic, homeless or is an injecting drug user. HIV-infected persons shall be screened annually; and

(d) a member whose screening tuberculin test is positive (>10 mm of induration) must be referred to the local DOH public health office in his or her community of residence for contact investigation.

(12) *Serum cholesterol measurement*: A male member 35 years and older and a female member 45 years and older who is at normal risk for coronary heart disease shall receive serum cholesterol and HDL cholesterol measurement every five years. A member 20 years and older with risk factors for heart disease shall have serum cholesterol and HDL cholesterol measurements annually.

(13) *Tot-to-teen health checks*: The MCO shall operate the tot-to-teen mandated EPSDT program as outlined in 8.320.2 NMAC. Within three months of enrollment lock-in, the MCO shall ensure that the member is current according to the screening schedule, unless more stringent requirements are specified in these standards. The MCO shall encourage its PCPs to assess and document for age, height, gender appropriate weight, and body mass index (BMI) percentage during EPSDT screens to detect and treat evidence of weight or obesity issues in members under 21 years of age.

(14) *Screening for type 2 diabetes*: A member with one or more of the following risk factors for diabetes shall be screened. Risk factors include:

(a) a family history of diabetes (parent or sibling with diabetes); obesity (>twenty percent over desired body weight or BMI >27kg/m2);

(b) race or ethnicity (e.g. hispanic, native American, African American, Asian-Pacific islander);

(c) 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); and

(d) a delivery of newborn over nine pounds.

(15) A member 21 years of age and older must be screened to detect high risk for behavioral health conditions at his or her first encounter with a PCP after enrollment.

(16) The MCO shall require its PCPs to refer a member, whenever clinically appropriate, to behavioral health provider, see 8.321.2 NMAC. The MCO shall assist the member with an appropriate behavioral health referral.

(17) Screens and preventative screens shall be updated as recommended by the United States preventative services task force.

[8.308.9.17 NMAC - Rp, 8.308.9.17 NMAC, 5/1/2018; A, 1/1/2019; A, 4/5/2022]

8.308.9.19 BEHAVIORAL HEALTH SERVICES:

A. The MCO shall cover the following behavioral health services listed below. When an additional behavioral health service is approved by MAD, the MCO shall cover that service as well. See 8.321.2 NMAC for detailed descriptions of each service. MAD makes available on its website its behavioral health service definitions and crosswalk, along with other information.

(1) Applied behavior analysis: The benefit package includes applied behavior analysis (ABA) services for [~~a member 12 months of age up to 21 years of age who has a well-documented medical diagnosis of autism spectrum disorder (ASD), and for a member 12 months to three years of age who has a well-documented risk for the development of ASD. The need for ABA services must be identified in the member's tot to teen healthcheck screen or another diagnostic evaluation furnished through a healthcheck referral.~~] eligible recipients who have a well-documented medical diagnosis of autism spectrum disorder (ASD), and for eligible recipients who have well-documented risk for the development of ASD. As part of a three-stage comprehensive approach consisting of evaluation, assessment, and treatment, ABA services may be provided in coordination with other medically necessary services (e.g., family infant toddler program (FIT) services, occupational therapy, speech language therapy, medication management, developmentally disabled waiver services, etc.). ABA services are part

of the early periodic screening, diagnosis and treatment (EPSDT) program (CFR 42 section 441.57). There is no age requirement to receive ABA services and ABA is a covered benefit for medicaid-enrolled adults.

(2) Assertive community treatment services (ACT): The benefit package includes assertive community treatment services for a member 18 years of age and older.

(3) Behavioral health respite: Behavioral health respite care is provided to a member under 21 years of age to support the member's family and strengthen their resiliency during the respite while the member is in a supportive environment. Respite care is provided to a member with a severe emotional disturbance who resides with his or her family and displays challenging behaviors that may periodically overwhelm the member's family's ability to provide ongoing supportive care. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines-respite services-for a detailed description. Behavioral health respite is not a benefit for ABP eligible recipients.

(4) Comprehensive community support services: The benefit package includes comprehensive community support services for a member.

(5) Crisis Services: The benefit package includes three types of crisis services:

(a) 24-hour crisis telephone support; and

(b) mobile crisis team; and

(c) crisis triage centers.

(6) Family support services: The benefit package includes family support services to a member whose focus is on the member and his or her family and the interactive effect through a variety of informational and supportive activities that assists the member and his or her family develop patterns of interaction that promote wellness and recovery over time. The positive interactive effect between the member and his or her family strengthens the effectiveness of other treatment and recovery initiatives. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -family support services- for a detailed description. Family support services are not a benefit for ABP eligible recipients.

(7) Hospital outpatient services: The benefit package includes outpatient psychiatric and partial hospitalization services provided in PPS-exempt unit of a general hospital for a member.

(8) Inpatient hospital services: The benefit package includes inpatient hospital psychiatric services provided in general hospital units and prospective payment system (PPS)-exempt units in a general hospital as detailed in 8.311.2 NMAC.

(9) Intensive outpatient (IOP) services: The benefit package includes intensive outpatient services for a member 13 years of age.

(10) Medication assisted treatment (MAT) and Opioid Treatment Programs: The benefit package includes opioid treatment services for opioid addiction to a member through an opioid treatment center as defined in 42 CFR Part 8, Certification of Opioid Treatment; and buprenorphine and related pharmaceuticals. Medication assisted treatments include use of buprenorphine and similarly acting products.

(11) Outpatient therapy services: The benefit package includes outpatient therapy services (individual, family, and group) for a member.

(12) Psychological rehabilitation services: The benefit package includes adult psychosocial rehabilitation services for a member 18 years and older.

(13) Recovery services: The MCO benefit package includes recovery services for a member. Recovery services are peer-to-peer support within a group setting to develop and enhance wellness and healthcare practices. The service enables a member to identify additional needs and goals and link him or herself to additional support as a result. See the New Mexico interagency behavioral health purchasing collaborative service requirements and utilization guidelines -recovery services-for a detailed description. Recovery services are not a benefit for ABP eligible recipients.

B. Behavioral health EPSDT services: The benefit package includes the delivery of the federally mandated EPSDT services (42 CFR Section 441.57) provided by a behavioral health practitioner for a member under 21 years of age. See 8.321.2 NMAC for a detailed description of each service. The MCO shall provide access to EPSDT for a member identified in his or her EPSDT tot to teen health check screen or another diagnostic evaluation as being at-risk for developing or having a severe emotional, behavioral or neurobiological disorder.

(1) Accredited residential treatment center (ARTC): The benefit package includes services furnished in an ARTC furnished as part of the EPSDT program. ARTC services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for ARTC services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(2) Behavior management skills development services (BMS): The benefit package includes BMS services furnished as part of the EPSDT program. BMS services are provided to a member who has an identified need for such services and meets the required LOC. The need for BMS services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(3) Day treatment services: The benefit package includes day treatment services furnished as part of the EPSDT program. Day treatment services are provided to a member who has an identified need for such services and meets the required LOC. The need for day treatment services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(4) Inpatient hospitalization services provided in freestanding psychiatric hospitals: The benefit package includes inpatient psychiatric care furnished in a freestanding psychiatric hospital furnished as part of the EPSDT program. Inpatient hospitalization services are provided in a freestanding psychiatric hospital are provided to a member who has an identified need for such services and meet the required LOC. The need for such services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(5) Multi-systemic therapy (MST): The benefit package includes MST services furnished as part of the EPSDT program. MST services are provided to a member who has an identified need for such services and meets the required LOC. The need for MST services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(6) Psychosocial rehabilitation services (PSR): The benefit package includes PSR services furnished as part of the EPSDT program. PSR is provided to a member who has an identified need for such services and meets the required LOC. The need for PSR services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

(7) Treatment foster care I (TFC I): The benefit package includes TFC I furnished as part of the EPSDT program. TFC I services are provided to a member who has an identified need for such services and meets the required LOC. The need for TFC I services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(8) Treatment foster care II (TFC II): The benefit package includes TFC II services furnished as part of the EPSDT program. TFC II is provided to a member who has an identified need for such services and meets the required LOC. The need for TFC II services must be identified in the member's tot to teen health check or another diagnostic evaluation furnished through a health check referral.

(9) Residential non-accredited treatment center (RTC) and group home: The benefit package includes services furnished in a RTC center or group home as part of the EPSDT program. RTC or group home services are provided to a member who needs the LOC furnished in an out-of-home residential setting. The need for RTC and group home services must be identified in the member's tot to teen health check screen or another diagnostic evaluation furnished through a health check referral.

[8.308.9.19 NMAC - Rp, 8.308.9.19 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.22 MAD ALTERNATIVE BENEFITS PLAN GENERAL BENEFITS FOR ABP EXEMPT MEMBERS (ABP exempt): An ABP member who self-declares [~~he or she has~~] they have a qualifying condition is evaluated by [~~his or her~~] their MCO for determination if [~~he or she meets~~] they meet an ABP qualifying condition. An ABP exempt member may select to no longer utilize [~~his or her~~] their ABP benefits package. Instead, the ABP exempt member will utilize [~~his or her~~] their MCO's medicaid benefits package. See 8.308.9.11-20 NMAC for detailed description of the MCO medicaid benefit services. All services, services limitations and co-payments that apply to full benefit medicaid recipients apply to APB-exempt recipients. An ABP-exempt recipient does not have access to the benefits that only apply to ABP recipients. The ABP co-payments do not apply to an ABP-exempt recipient. The limitations on services that apply only to ABP-recipients do not apply to ABP-exempt recipients. The MCO shall comply with all HSD contractual provisions and with all NMAC rules that pertain to the MCO's responsibilities to its members as listed below:

A. provider networks found in 8.308.2 NMAC;
B. managed care eligibility found in 8.308.6 NMAC;
C. enrollment and disenrollment from managed care found in 8.308.7 NMAC;
D. managed care member education - rights and responsibilities found in 8.308.8 NMAC;
E. care coordination found in 8.308.10 NMAC;
F. transition of care found in 8.308.11 NMAC;
G. community benefits found in 8.308.12 NMAC;

H. managed care member rewards found in 8.308.13 NMAC
I. managed care cost sharing found in 8.308.14 NMAC;
J. managed care grievance and appeals found in 8.308.15 NMAC;
K. managed care reimbursement found in 8.308.20 NMAC;
L. quality management found in 8.308.21 NMAC; and
M. managed care fraud, waste and abuse found in 8.308.22 NMAC.

[8.308.9.22 NMAC - Rp, 8.308.9.22 NMAC, 5/1/2018; A, 4/5/2022]

8.308.9.23 CENTENNIAL HOME VISITING (CHV) PILOT PROGRAM SERVICES: Beginning January 1, 2019, the benefit is available to approximately 300 eligible pregnant medicaid managed care enrolled members and their children who reside in Bernalillo County (other HSD-designated counties may be included at a later time and with a distinct enrollment limit) in accordance with the program standard. The MCO shall contract with agencies operating in the HSD-designated counties that provide services that are in alignment with one of the two following evidence-based early childhood home visiting delivery models:

A. Nurse Family Partnership (NFP): The services to be delivered under the NFP national program standards are for first-time parents only. In Bernalillo County, the program is anticipated to serve up to 132 families by the end of the first year of implementation using one NFP team and to approximately 240 eligible members (annual average at full implementation) thereafter using two NFP teams. The number of families served will be determined based on the number of active NFP teams in any program year. HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity. The NFP services will be suspended once the child reaches two years of age.

B. Parents as Teachers (PAT): The PAT evidence-based program services will adhere to the national model and curriculum and serve approximately 60 families (annual average at full implementation) in Bernalillo County. Services will begin during pregnancy and may continue until the child reaches five years of age or kindergarten entry. HSD may expand this program to other counties at HSD's discretion dependent upon provider capacity. The number of families served in other counties will be determined based on the number of active PAT teams in the program year. The MCO may propose other evidence-based early childhood home visiting delivery models with similar services in lieu of the PAT model if available in the HSD-designated service areas.

C. Description of Services: The services available under the CHV pilot program are described below:

(1) Prenatal home visits: the benefit package includes the following services for eligible pregnant [~~women~~] individuals during their pregnancy:

(a) monitoring for high blood pressure or other complications of pregnancy (only covered under the NFP model);
(b) diet and nutritional education;
(c) stress management;
(d) sexually transmitted disease (STD) prevention education;
(e) tobacco use screening and cessation education;
(f) alcohol and other substance misuse screening and counseling;
(g) depression screening; and
(h) domestic and intimate partner violence screening and education.

(2) Postpartum home visits: the benefit package includes the following services that may be delivered as part of a postpartum home visit, when provided during the [~~60-day~~] 12-month postpartum period to an eligible member:

(a) diet and nutritional education;
(b) stress management;
(c) sexually transmitted disease (STD) prevention education;
(d) tobacco use screening and cessation education;
(e) alcohol use and other substance misuse screening and counseling;
(f) depression screening;
(g) domestic and intimate partner violence screening and education;
(h) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;
(i) guidance and education regarding wellness visits to obtain recommended preventive services;

(j) medical assessment of the postpartum mother and infant (only covered under the NFP model);

(k) maternal-infant safety assessment and education, such as safe sleep education for sudden infant death syndrome (SIDS) prevention;

(l) counseling regarding postpartum recovery, family planning, and needs of a newborn;

(m) assistance to the family in establishing a primary source of care and a primary care provider, including help ensuring that the mother/infant has a postpartum/newborn visit scheduled; and

(n) parenting skills and confidence building.

(3) Infant and children home visits: the benefit package includes the following services that may be delivered to newborn infants born to CHV Pilot Project members until the child reaches two years of age for NFP and five years of age or kindergarten entry for PAT, as part of an infant home visit:

(a) breastfeeding support and education. Members may be referred to a lactation specialist, but lactation consultant services are not covered as a home visiting service;

(b) child developmental screening at major developmental milestones from birth to age two for NFP according to the model standard practice, and age five or kindergarten entry for PAT; and

(c) parenting skills and confidence building.

[8.308.9.23 NMAC - N, 1/1/2019; A, 4/5/2022]

8.308.9.25 EMERGENCY AND POST STABILIZATION SERVICES:

A. In this section, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, for a pregnant [~~woman~~] individual, the health of the [~~woman or her~~] individual or their unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

B. In this section, emergency services means covered inpatient and outpatient services as follows.

(1) Furnished by a provider that is qualified to furnish these services under the federal rules. See 42 CFR 438.114.

(2) Needed to evaluate or stabilize an emergency medical condition.

C. Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described 42 CFR 438.114 (e), to improve or resolve the member's condition.

D. The MCO is responsible for coverage and payment of emergency services and post-stabilization care services. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO. The MCO may not deny payment for treatment obtained under either of the following circumstances.

(1) A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of emergency medical condition in Subsection A of 8.308.9.24 NMAC.

(2) A representative of the MCO instructs the member to seek emergency services.

E. The MCO may not:

(1) limit what constitutes an emergency medical condition with reference to Subsection A of 8.308.9.24 NMAC on the basis of lists of diagnoses or symptoms; or

(2) refuse to cover emergency services based on the emergency room provider or hospital not notifying the member's PCP or the MCO.

F. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

G. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCO that is responsible for coverage and payment.

[8.308.9.24 NMAC - Rp, 8.308.9.24 NMAC, 5/1/2018; 8.308.9.25 NMAC - Rn, 8.308.9.24 NMAC, 1/1/2019; A, 4/5/2022]