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

8.308.10.1 ISSUING AGENCY: New Mexico Human Services Department (HSD).
[8.308.10.1 NMAC - Rp, 8.308.10.1 NMAC, 5/1/2018]

8.308.10.2 SCOPE: This rule applies to the general public.
[8.308.10.2 NMAC - Rp, 8.308.10.2 NMAC, 5/1/2018]

8.308.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-1-12 et seq., NMSA 1978.
[8.308.10.3 NMAC - Rp, 8.308.10.3 NMAC, 5/1/2018]

8.308.10.4 DURATION: Permanent.
[8.308.10.4 NMAC - Rp, 8.308.10.4 NMAC, 5/1/2018]

8.308.10.5 EFFECTIVE DATE: May 1, 2018, unless a later date is cited at the end of a section.
[8.308.10.5 NMAC - Rp, 8.308.10.5 NMAC, 5/1/2018]

8.308.10.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.308.10.6 NMAC - Rp, 8.308.10.6 NMAC, 5/1/2018]

8.308.10.7 DEFINITIONS: [**RESERVED**]

8.308.10.8 [**RESERVED**]
[8.308.10.8 NMAC - Rp, 8.308.10.8 NMAC, 5/1/2018]

8.308.10.9 CARE COORDINATION:

A. General requirements:

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

(2) Every member has the right to refuse to participate in care coordination. In the event the member refuses this service, the managed care organization (MCO) will document the refusal in the member's file and report to HSD. The member remains enrolled with the MCO with no reduction in the availability of services.

(3) If a native American member requests assignment to a native American care coordinator, the MCO must employ or contract with a native American care coordinator or contract with a community health representative (CHR) to serve as the care coordinator.

(4) Individuals with special health care needs (ISHCN) require a broad range of primary, specialized medical, behavioral health and related services. ISHCN are individuals who have, or are at an increased risk for, a chronic physical, developmental, behavioral, neurobiological or emotional condition and who require health and related services of a type or amount beyond that required by other members. ISHCN have ongoing health conditions, high or complex service utilization, and low to severe functional limitations. The primary purpose of the definition is to identify these members so that the MCO shall facilitate access to appropriate services through its care coordination process and comply with provisions of 42 CFR Section 438.208.

B. Health risk assessment (HRA): The MCO shall conduct a HSD approved health risk assessment

(HRA) either by telephone, in person or as otherwise approved by HSD. The HRA is conducted for the purpose of:

(1) introducing the MCO to the member;

(2) obtaining basic health and demographic information about the member; and

(3) confirming the need for a comprehensive needs assessment (CNA); and

(4) determining the need for a nursing facility (NF) level of care (LOC) assessment, as applicable. Requirements for health risk assessments are defined in the HSD managed care policy manual (section 04 care coordination).

C. Assignment to care coordination levels two and three: The MCO shall conduct a HSD approved CNA to assess the member's medical, behavioral health, and long term care needs and determine the care coordination level. Requirements for care coordination level two and three determinations are defined in the HSD managed care policy manual (section 04 care coordination).

D. Increase in the level of care coordination services: The requirements establishing a need for a CNA for a higher level of care coordination determination are defined in the HSD managed care policy manual (section 04 care coordination).

E. Comprehensive care plan requirements: The MCO shall develop a comprehensive care plan (CCP) for members in care coordination levels two and three. Requirements for CCP development are defined in the HSD managed care policy manual (section 04 care coordination).

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

(1) drug therapy;

(2) laboratory and radiology results;

(3) sentinel events, such as hospitalization, emergencies, or incarceration;

(4) discharge from a psychiatric hospital, a residential treatment service, treatment foster care or from other behavioral health services; and

(5) all LOC transitions.

G. Electronic visit verification (EVV) system:

(1) The MCO, together with the other MCOs, shall contract with a vendor to implement an EVV system in accordance with the federal Twenty First Century Cures Act.

(2) The MCO shall maintain an EVV system capable of leveraging up to date technology as it emerges to improve functionality in all areas of the state, including rural areas.

[8.308.10.9 NMAC - Rp, 8.308.10.9 NMAC, 5/1/2018]

HISTORY OF 8.308.10 NMAC: [RESERVED]

History of Repealed Material:

8.308.10 NMAC - Managed Care Program, Care Coordination, filed 12/17/2013 Repealed effective 5/1/2018.