TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 10 HEALTH HOME SERVICES

8.310.10.1 ISSUING AGENCY: New Mexico Health Care Authority (HCA).
[8.310.10.1 NMAC - N, 4/1/2016; A, 9/1/2024]

8.310.10.2 SCOPE: The rule applies to the general public.
[8.310.10.2 NMAC - N, 4/1/2016]

8.310.10.3 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 Sections 27-2-12 et seq. NMSA 1978.
[8.310.10.3 NMAC - N, 4/1/2016]

8.310.10.4 DURATION: Permanent.
[8.310.10.4 NMAC - N, 4/1/2016]

8.310.10.5 EFFECTIVE DATE: April 1, 2016, unless a later date is cited at the end of a section.
[8.310.10.5 NMAC - N, 4/1/2016]

8.310.10.6 OBJECTIVE: The objective of this rule is to provide instructions for the service portion of the New Mexico medical assistance programs (MAP).
[8.310.10.6 NMAC - N, 4/1/2016]

8.310.10.7 DEFINITIONS: [RESERVED]

8.310.10.8 MISSION: We ensure that New Mexicans attain their highest level of health by providing whole-person, cost-effective, accessible, and high-quality health care and safety-net services.
[8.310.10.8 NMAC - N, 4/1/2016; Repealed, 5/1/2018; A, 9/1/2024]

8.310.10.9 HEALTH HOMES: CareLink NM is a set of services authorized by Section 2703 of the Affordable Care Act (ACA). CareLink NM health home (CareLink NM) services are delivered through a designated provider agency. In addition to being enrolled as a provider, a provider agency must complete a CareLink NM application and successfully complete a readiness assessment by HCA prior to becoming a designated health home. CareLink NM services enhance the integration and the coordination of primary, acute, behavioral health, and long-term services and supports. The CareLink NM provider agency assists an eligible recipient by engaging them in a comprehensive needs assessment which is then utilized to develop their integrated service plan and individual treatment plan, increasing their access to health education and promotion activities, monitoring the eligible recipient's treatment outcomes and utilization of resources, coordinating appointments with the eligible recipient's primary care and specialty practitioners, sharing information among their physical and behavioral practitioners to reduce the duplication of services, actively managing the eligible recipient's transitions between services, and participating as appropriate in the development of the eligible recipient's hospital discharge.
[8.310.10.9 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.10 ELIGIBLE PROVIDERS AND PRACTITIONERS:

A. Health care to eligible recipients in a health home is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by medical assistance division (MAD). Upon approval of a New Mexico provider participation agreement (PPA) by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider agency must be enrolled before submitting a claim for payment to the MAD claims processing contractors or the HCA contracted managed care organizations (MCOs). MAD makes available on the HCA website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by MAD or its designees including program rules, billing instructions, utilization review (UR) instructions, supplements, policy, and other

pertinent materials. When enrolled, a provider agency and a practitioner receive instruction on how to access these documents. It is the provider agency's and practitioner's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider agency must contact HCA or its authorized agents to obtain answers to questions related to the material. To be eligible for reimbursement, a provider agency and practitioner must adhere to the provisions of the MAD PPA and all applicable statutes, regulations, and executive orders. MAD, its selected claims processing contractor or the MCO, issues payments to a provider agency using electronic funds transfer (EFT) only. To be eligible to receive a CareLink NM health home designation, a provider agency must hold a comprehensive community support service (CCSS) certification or attest that the agency has received all required training.

B. A provider agency must follow CareLink NM staffing requirements found in this rule and further detailed in the CareLink NM policy manual. The provider agency must agree to fulfill other responsibilities as listed in Subsection B of 8.310.10.10 NMAC. The following individuals and practitioners must be contracted or employed by the provider agency as part of its CareLink NM service delivery:

(1) A director specifically assigned to CareLink NM service oversight and administrative responsibilities.

(2) A health promotion coordinator with a bachelor's-level degree in a human or health services field and experience in developing curriculum and curriculum instruction. The health promotion coordinator manages health promotion services and resources appropriate for an eligible recipient such as interventions related to substance use prevention and cessation, nutritional counseling, or health weight management;

(3) A care coordinator who develops and oversees an eligible recipient's comprehensive care management, including the planning and coordination of all physical, behavioral, and support services. The number of care coordinators is based upon ratio in Paragraph (5) of Subsection D of 8.310.10.11 NMAC. The care coordinator:

(a) is a regulation and licensing department (RLD) licensed behavioral health practitioner; or

(b) holds a bachelor's or master's level degree and has two years of relevant healthcare experience; or

(c) is registered nurse in the State of New Mexico; or

(d) is approved through the CLNM NM health home steering committee.

(4) A community liaison who speaks a language that is utilized by a majority of non-fluent English-speaking eligible recipients, and who is experienced with the resources in the eligible recipient's local community. The community liaison identifies, connects, and engages with community services, resources, and providers. The community liaison works with an eligible recipient's care coordinator in appropriately connecting and integrating the eligible recipient to needed community services, resources, and practitioners.

(5) A supervisor who is an independently licensed behavioral health practitioner as described in 8.321.2 NMAC who supervises the care coordinator, the community liaison, the health promotion coordinator, peer and family support workers, and other optional staff that is the part of the CareLink NM multidisciplinary team. The supervisor must have direct service experience in working with both adult and child populations. Physical health and psychiatric consultants must comply with their respective licensing boards' requirements for supervision.

(6) Certified peer support worker(s) (CPSW) who hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker. The CPSW has successfully navigated their own behavioral health experiences, and is willing to assist their peers in their recovery processes.

(7) Certified family support specialist(s) who hold a certification by the New Mexico credentialing board for behavioral health professionals as a certified family support worker.

(8) A physical health consultant who is a physician licensed to practice medicine (MD) or osteopathy (DO), a licensed certified nurse practitioner (CNP), or a licensed certified nurse specialist (CNS) as described in 8.310.3 NMAC.

(9) A psychiatric consultant who is a physician (MD or DO) licensed by the board of medical examiners or board of osteopathy and is board-eligible or board-certified in psychiatry as described in 8.321.2 NMAC.

[8.310.10.10 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.11 PROVIDER RESPONSIBILITIES:

A. A provider agency who furnishes MAD services to an eligible recipient must comply with all federal and state laws, rules, regulations, and executive orders relevant to the provision of services as specified in the MAD PPA. A provider agency also must comply with all appropriate New Mexico administrative code (NMAC) rules, billing instructions, supplements, and policy, as updated. A provider agency is also responsible for following coding manual guidelines and centers for medicare and medicaid services (CMS) national correct coding initiatives (NCCI), including not improperly unbundling or upcoding services.

B. A provider agency must verify that a recipient is eligible for a specific health care program administered by HCA and its authorized agents, and must verify the recipient's enrollment status at the time services are furnished. A provider agency must determine if an eligible recipient has other health insurance and notify HCA. A provider agency must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient.

C. When services are billed to and paid by a MAD fee-for-service (FFS) coordinated services contractor authorized by HCA, under an administrative services contract, the provider agency must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services; see 8.302.1 NMAC.

D. The provider agency must:

(1) demonstrate the ability to meet all data and quality reporting requirements as detailed in the CareLink NM policy manual;

(2) be approved through a HCA application and readiness process as described in the CareLink NM policy manual;

(3) have the ability to provide primary care services for all ages of eligible recipients, or have a memorandum of agreement with at least one primary care practice in the area that serves eligible recipients under 21 years of age, and one that serves eligible recipients 21 years of age and older;

(4) have established eligible recipient referral protocols with the area hospitals and residential treatment facilities;

(5) maintain the following suggested range of care coordinator staff ratios for CareLink NM eligible recipients as described in the CareLink NM policy manual:

(a) 1:51-100 for care coordination level 6;

(b) 1:30-50 for care coordination level 7;

(c) 1:50 for care coordination level 8; and

(d) 1:10 for care coordination level 9.

E. For the provider agency that renders physical health and behavioral health services, additional staff may be included; see CareLink NM policy manual for detailed descriptions.

[8.310.10.11 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.12 IDENTIFIED POPULATION: An eligible recipient:

A. is 21 years of age and older who meets the HCA criteria for serious mental illness (SMI); or

B. is under 21 years of age who meets the HCA criteria for serious emotional disturbance (SED); or

C. meets the criteria for substance use disorder (SUD).

[8.310.10.12 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.13 COVERED SERVICES: Health home services through CareLink NM are coordinated with the eligible recipient and their family and a CareLink NM provider agency as appropriate. CareLink NM services identify available community-based resources and actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post engagement. Common linkages include continuation of the eligible recipient's MAP category of eligibility, and their other disability benefits, housing assistance, legal services, educational and employment supports, and other personal needs consistent with their recovery goals and CareLink NM care plan. CareLink NM staff make and follow-up on referrals to community services, link an eligible recipient with natural supports, and assure that these connections are solid and effective. Services are linked as appropriate and feasible by health information technology. CareLink NM services are comprised of six unique categories (and further defined in the CareLink NM policy manual):

A. comprehensive care management;

B. care coordination;

C. health promotion;

D. comprehensive transitional care;

E. individual and family support services; and

F. referrals for the eligible recipient to community and social support services.
[8.310.10.13 NMAC - N, 4/1/2016; A, 5/1/2018; A, 9/1/2024]

8.310.10.14 GENERAL NON-COVERED SERVICES: Non-covered CareLink NM services are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.310.2 and 8.321.2 NMAC for general non-covered services. Specific to CareLink NM services, the following apply:

A. CareLink NM services rendered during an eligible recipient's stay in an acute care or freestanding psychiatric hospital and a residential treatment facility (not to include foster care and treatment foster care placements), except when part of the eligible recipient's transition plan, are not covered services.

B. Services which duplicate other MAD services, including care coordination activities that the MCO has not delegated to the provider agency, are not covered services.
[8.310.10.14 NMAC - N, 5/1/2018]

8.310.10.15 PRIOR AUTHORIZATION (PA) AND UTILIZATION REVIEW (UR): All MAD services are subject to utilization review (UR) for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished, before payment is made, or after payment is made. The provider agency must contact MAD or its designees to request UR instructions. It is the provider agency's responsibility to access these instructions or ask for hard copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HCA, the provider agency and practitioner must follow that contractor's instructions for authorization of services. A provider agency and practitioner rendering services to a member must comply with that MCO's prior authorization requirements.

A. Prior authorization: CareLink NM services do not require prior authorization, but are provided as approved by the CareLink provider agency. However, other procedures or services may require a prior authorization from MAD or its designee. Services for which a prior authorization is required remain subject to UR at any point in the payment process, including after payment has been made. It is the provider agency's responsibility to contact MAD or its designee and review documents and instructions available from MAD or its designee to determine when a prior authorization is necessary.

B. Timing of UR: A UR may be performed at any time during the service, payment, or post payment processes. In signing the MAD PPA, a provider agency agrees to cooperate fully with MAD or its designee in its performance of any review and agrees to comply with all review requirements. The following are examples of the reviews that may be performed:

(1) prior authorization review (review occurs before the service is furnished);

(2) concurrent review (review occurs while service is being furnished);

(3) pre-payment review (claims review occurring after service is furnished but before payment);

(4) retrospective review (review occurs after payment is made); and

(5) one or more reviews may be used by MAD to assess the medical necessity and program compliance of any service.

C. Denial of payment: If a service or procedure is not medically necessary or not a covered MAD service, MAD may deny a provider agency's claim for payment. If MAD determines that a service is not medically necessary before the claim payment, the claim is denied. If this determination is made after payment, the payment amount is subject to recoupment or repayment.

D. Review of decisions: A provider agency that disagrees with a prior authorization request denial or another review decision may request reconsideration from MAD or the MAD designee that performed the initial review and issued the initial decision; see 8.350.2 NMAC. A provider agency that is not satisfied with the reconsideration determination may request a HCA provider administrative hearing; see 8.352.3 NMAC. A provider agency that disagrees with the member's MCO decision is to follow the process detailed in 8.308.15 NMAC.
[8.310.10.15 NMAC - N, 5/1/2018; A, 9/1/2024]

8.310.10.16 PAYMENT FOR SERVICES AND BILLING INSTRUCTION: CareLink NM services are reimbursed through a per-member-per-month (PMPM) payment to the provider agency. CareLink NM dedicated services are those outlined in 8.310.10.13 NMAC. MAD covered services provided to an eligible recipient including behavioral and physical health services, are billed and reimbursed independent of the PMPM payment to the provider agency. The PMPM reimbursement is paid for CareLink NM services regardless of whether the eligible recipient is a MCO member or enrolled in fee-for-service (FFS). The CareLink NM provider agency is

responsible for verifying that the eligible recipient has affirmatively agreed to participate in CareLink NM services, documentation of which should be in a signed statement in the eligible recipient's file, in order to receive reimbursement. PMPM codes will be used to document various CareLink NM services provided to an eligible recipient, and trigger the PMPM reimbursement. To receive reimbursement, the provider agency must fully execute at least one CareLink NM service in a given month, meaning direct contact and interaction with an eligible recipient to deliver comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, or referral to community and support services. A non-exhaustive list of actions by a CareLink NM provider agency that fail to meet full execution of a CareLink NM service includes attempting to call or visit an eligible member. For referral to community and support services that may not include direct contact with an eligible recipient, the provider agency must, at a minimum, include a service referral and a follow-up with the service provider after the eligible recipient engagement, in order to receive reimbursement.

A. Fee-for-service (FFS) reimbursement: For an eligible recipient who is utilizing FFS benefits, the provider agency will submit a PMPM health home code through the fiscal agent's claims system when a CareLink NM service is provided to an eligible recipient, which will then result in a PMPM payment. The requirement for the provider agency to submit a claim for payment allows HCA to ensure that the eligible recipient receives the CareLink NM service before payment is made. If a CareLink NM service is not provided to an eligible recipient in a given month, the provider agency will not receive a PMPM payment. The claims submission also provides data to HCA on CareLink NM services rendered and the date of service for monitoring and evaluation purposes including outcome and quality studies.

B. Managed care reimbursement: For an eligible recipient who is a member of a MCO, the provider agency and the MCO shall negotiate reimbursement at an amount no less than the established PMPM rate for a health home.

[8.310.10.16 NMAC - N, 4/1/2016; A, 9/1/2024]

HISTORY OF 8.310.10 NMAC: [RESERVED]