Bill Richardson
Governor

Pamela S. Hyde, J.D.
Secretary

DATE: April 26, 2005

TO: Judy Enright, ValueOptions

FROM: Carolyn Ingram, Director of Medical Assistance Division

SUBJECT: Letter of Direction #1, Regarding Financial Issues

This Letter of Direction is in response to questions from ValueOptions concerning financial issues from the collaborative and individual funding agencies. Responses to the questions below only apply to Human Services Department/Medical Assistance Division (HSD/MAD).

Human Services Department/Medical Assistance Division Finance Streams

A. For each funding stream within a funding agency, how will the SE be paid? When will the SE be paid?

- Medicaid will establish the BH SE as a MCO type provider with two plans: Managed Care and Coordinated Services Program. Medicaid clients will be enrolled in the BH SE in one of those two plans, based on whether the client is enrolled in SALUD! (these are the Managed Care clients) or the client is in FFS for behavioral health needs (these are the Coordinated Services Program clients).

- Native American clients who are not in SALUD! will initially be assigned to the BH SE Coordinated Services Program. However, those Native Americans who are not Dual Eligible and not enrolled in SALUD! will have the ability to “opt-in” to the BH SE Managed Care program by contacting Medical Assistance and requesting enrollment to the BH SE Managed Care program.

- There will be five (5) cohorts established for the Managed Care BH plan. Each cohort has a different per member per month reimbursement rate. Clients are assigned to a cohort based on the client’s category of eligibility and age.

- There will be a rate paid for all clients assigned to the Coordinated Service Program plan.

- Omnicaid will generate a separate roster file for each plan and a separate capitation file for each plan. Rosters are generated the 3rd business day before the end of the month and placed in a password protected website for the SE to download. Therefore, for the enrollment month of July 2005, the enrollment roster file will be made available to the BH SE (via secure FTP) the morning of June 28, 2005.

- The roster file shows all clients enrolled with the SE for the upcoming enrollment month as well as any clients terminated for that enrollment month. The Major and minor type reported on the roster indicate whether the enrollment record being reported is a new enrollment.

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(value = E1), ongoing enrollment (value = E2), termination (value = T3), recoupment (value = X5), or retroactive enrollment span (value = R4).

➢ The Roster file will also report to the SE any other Managed Care or Coordinated Services Programs that the client is enrolled with so that the SE will know with which providers to coordinate services.

➢ The system also creates a supplemental roster file that runs on the first of the month to capture any clients with eligibility changes that occurred within those last three days of the month. Only those clients with changes that affected their enrollment to the SE are reported on the supplemental file.

➢ Both managed care and Coordinated Services Program payments will be paid as part of the first weekend cycle in each month. Therefore, the BH SE payments for Medicaid clients for the enrollment month of July will be generated out of the cycle that runs the weekend of July 1 and a warrant issued to the BH SE on Monday July 4, 2005.

B. What is the invoice format required by funding stream?
➢ For managed care and coordinated services no invoices will be necessary, as all payments will be generated by the system.

C. How should allocation of administrative expense across funding sites within a funding agency?
➢ Managed care is allocated at 85% service and 15% administration (including taxes). Coordinated Services is allocated at 90% for services and 10% for administration (including taxes). The full listing of administrative expenses is included within the RFP.

D. Where do we need to send invoices for payments?
➢ For managed care and coordinated services no invoices will be necessary, as all payments will be generated by the system.

E. Please provide confirmation of bank account structure for claims, reinvestment, withholds, etc.
➢ HSD/MAD does not have specific requirements for how the SE should structure accounts for claims or reinvestments, but HSD/MAD will need information on how these accounts are established for review.
➢ In the case of withhold accounts these funds will need to be placed in escrow until it is determined that the SE has met the contractually required performance measures.

F. Please provide confirmation of reinvestment percentage for each funding stream within a funding agency.
➢ More detailed information concerning reinvestment will be provided by May 1, 2005.

G. Which Financial reports will be required?
➢ Copies of the reports were sent to Anthony Ritter of ValueOptions on April 13, 2005.

H. What is required for OMB reimbursement for IHS facilities and Tribal programs?
➢ The SE is required to pay the IHS all-inclusive rate (OMB rate) to IHS and Tribal 638 facilities (identified as provider type 221 in the file of Medicaid providers) for Managed Care or Coordinated Service Program clients. This rate is established annually by IHS and the Federal Office of Management and Budget and is published annually in the federal register. The calendar year 2004 Medicaid inpatient per diem rate is $1,512 and the Medicaid outpatient visit rate is $216. HSD/MAD expects the calendar year 2005 rate to be published in the summer or fall of 2005. These rates will be retroactive back to date of service beginning 1/1/2005.
The SE is required to submit, on a quarterly basis, to HSD/MAD a report detailing a list of those payments (made to a provider type 221 provider) in a format established by HSD/MAD. HSD/MAD will conduct a reconciliation of those payments the SE. If an overpayment has been made HSD/MAD will recoup the required amount from the SE. If an underpayment has been made HSD/MAD will issue a payment to the SE.

I. Please clarify the reimbursement issues on QMB, SLMB and Medicaid/Medicare.
   ➢ Medicaid is not assigning QMB only’s to the SE. We do not have eligibility on SLMB, so these also would not be assigned.
   ➢ Medicaid/Medicare dual eligibles will be assigned to the SE under the Coordinated Services Program plan, for which a monthly fee will be made through the process described in “A.” above.
   ➢ HSD/MAD will continue to make payment on the crossover claims. HSD/MAD will send the SE a monthly file containing the processed crossover claims (paid and denied).

J. Please clarify FQHC reimbursement – Coordinated Services and Managed Care, will there be wraparound payments from the State?
   ➢ This process will proceed as it does with the current SALUD! contract. The SE will make payments to FQHCs for services rendered to Managed Care or Coordinated Service Program clients and is required to submit a report to HSD/MAD detailing those payments in a format established by HSD/MAD. HSD/MAD will determine the wraparound payments and make them directly to the FQHC.

K. For Medicaid members, how are retroactive eligibility changes handled? How is presumptive eligibility handled?
   ➢ When a client is determined eligible for Medicaid, they are enrolled with the SE for the upcoming enrollment month. Medicaid will not automatically be retroactively enrolling any members. If a provider contacts Medicaid or the SE with a request for approval of payment for services that would be covered by the SE for the client without prior authorization for a period the client was eligible but not enrolled, staff at Medical Assistance will create a retroactive lockin to the SE for that period. The client will show up on the next roster with a major type that shows ‘retroactive’ and the dates of the retroactive period and the system will generate the capitation for the retroactive period.

   ➢ Medicaid does not currently enroll presumptive eligibles (COE 071/3) in SALUD. Therefore, these clients will be assigned to the SE under the Coordinated Services program and the SE will be paid a fee for their coverage as negotiated in the contract with the SE.
DATE:       June 24, 2005

TO:         Pam Galbrath, Judy Enright, ValueOptions

FROM:       Carolyn Ingram, Director of Medical Assistance Division

SUBJECT:    Letter of Direction #2, Medicaid Provider Enrollment, Client Potential
            Enrollment, and IHS Rates

This Letter of Direction is for clarification to the Statewide Entity (SE) concerning Medicaid
provider enrollment, client potential enrollment, and Indian Health Services (IHS) calendar year
2005 rates.

Medicaid Provider Enrollment:

1. Does a Medicaid provider need to have a provider agreement with the Medicaid program to
   provide services?

   • In order to receive Medicaid payment from the SE for services provided to Fee-For-
     Service Behavioral Health clients, providers must first be Medicaid enrolled, have a
     signed provider agreement, and have an active Medicaid provider number.

   • A New Mexico Managed Care provider does not need to be Medicaid enrolled in order to
     provide service to Medicaid Behavioral Health clients and receive payment from the SE.

Medicaid Potential Enrollees File

2. What does the “Potential Enrollees File” contain?

The Potential Enrollees File contains all the Medicaid clients who have been enrolled in a
Managed Care or Coordinated Services Program for the upcoming enrollment month. This
file is not the final, accurate list of enrollees to each plan. The Potential Enrollees File only
contains clients enrolled during the previous week. This file is not a cumulative file. The
clients on the Potential Enrollees file have selected or been assigned to a MCO for the upcoming enrollment month, some change (such as client code, Medicaid eligibility, etc.) may occur between the time they make their selection and monthly enrollment roster generation.

**Indian Health Services (IHS) Rates for Calendar Year 2005**

3. What rate is paid to Indian Health Services (IHS)?

The SE is required to pay the IHS all-inclusive rate (OMB rate) to IHS and Tribal 638 facilities for services included within the rate. For services not included within this rate, they are paid at the Medicaid fee schedule or at a negotiated rate. These include inpatient physician services, target case management, RTC, and pharmacy.

The OMB rate is established annually by IHS and the Federal Office of Management and Budget and is published annually in the Federal Register. The calendar year 2005 Medicaid inpatient per diem rate is $1,542 and the Medicaid outpatient per encounter/visit rate is $223. Attached is a copy of the Federal Register Department of Health and Human Services Indian Health Service Reimbursement Rates for Calendar Year 2005.
words such as “must,” “shall,” and “will” in the original VICH document have been substituted with “should.” Similarly, words such as “require” or “requirement” have been replaced by “recommend” or “recommendation” as appropriate to the context.

The draft VICH guidance (#177) is consistent with the agency’s current thinking on the subject matter. This guidance does not create or confer any rights for or on any person and will not operate to bind FDA or the public. An alternative method may be used as long as it satisfies the requirements of applicable statutes and regulations.

IV. Comments

This draft guidance document is being distributed for comment purposes only and is not intended for implementation at this time. Interested persons may submit to the Division of Dockets Management (see ADDRESSES) written or electronic comments regarding this draft guidance document. Submit a single copy of electronic comments or two paper copies of any mailed comments, except that individuals may submit one paper copy. Comments are to be identified with the docket number found in brackets in the heading of this document. A copy of the draft guidance and received comments are available for public examination in the Division of Dockets Management between 9 a.m. and 4 p.m., Monday through Friday.

V. Electronic Access

Electronic comments may also be submitted via the Internet at http://www.fda.gov/dockets/comments. Once on this Internet site, select Docket No. 2005D–0200 entitled “Specifications: Test Procedures and Acceptance Criteria for New Biotechnological/Biological Veterinary Medicinal Products” (VICH GL40) and follow the directions.

Copies of the draft guidance document entitled “Specifications: Test Procedures and Acceptance Criteria for New Biotechnological/Biological Veterinary Medicinal Products” (VICH GL40) may be obtained on the Internet from the Center for Veterinary Medicine home page at http://www.fda.gov/cvm.

Dated: May 23, 2005.

Jeffrey Shuren,
Assistant Commissioner for Policy.
[FR Doc. 05–10825 Filed 5–24–05; 11:50 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Indian Health Service

Reimbursement Rates for Calendar Year 2005

AGENCY: Indian Health Service, HHS.

ACTION: Notice.

SUMMARY: Notice is given that the Director of Indian Health Service (IHS), under the authority of sections 321(a) and 322(b) of the Public Health Service Act (42 U.S.C. 248 and 249(b)), Public Law 85–568 (42 U.S.C. 2001(a)) and the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.), has approved the following rates for inpatient and outpatient medical care provided by IHS facilities for Calendar Year 2005 for Medicare and Medicaid Beneficiaries and Beneficiaries of other Federal Agencies. The Medicare Part A inpatient rates are excluded from the table below as they are paid based on the prospective payment system. Since the inpatient rates set forth below do not include all physician services and practitioner services, additional payment may be available to the extent that those services meet applicable requirements. Public Law 106–554, dated December 21, 2000, authorized IHS facilities to file Medicare Part B claims with the carrier for payment for physician and certain other practitioner services provided on or after July 1, 2001.

Inpatient Hospital Per Diem Rate (Excludes Physician/Practitioner Services)

Calendar Year 2005

Lower 48 States—$1,542

Alaska—$2,032

Outpatient Per Visit Rate (Excluding Medicare)

Calendar Year 2005

Lower 48 States—$223

Alaska—$391

Outpatient Per Visit Rate (Medicare)

Calendar Year 2005

Lower 48 States—$181

Alaska—$371

Medicare Part B Inpatient Ancillary Per Diem Rate

Calendar Year 2005

Lower 48 States—$312

Alaska—$635

Outpatient Surgery Rate (Medicare)

Established Medicare rates for freestanding Ambulatory Surgery Centers.

Effective Date for Calendar Year 2005 Rates

Consistent with previous annual rate revisions, the Calendar Year 2005 rates will be effective for services provided on or after January 1, 2005 to the extent consistent with payment authorities including the applicable Medicaid State plan.

Dated: May 20, 2005

Charles W. Grimm,
Assistant Surgeon General, Director, Indian Health Service.

[FR Doc. 05–10550 Filed 5–26–05; 8:45 am]

BILLING CODE 4160–16–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

[USCG–2005–21202]

Collection of Information Under Review by Office of Management and Budget (OMB): OMB Control Number: 1625–0018

AGENCY: Coast Guard, DHS.

ACTION: Request for comments.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995, the Coast Guard intends to seek the approval of OMB for the renewal of one Information Collection Request (ICR). The ICR comprises (1) 1625–0018, Official Logbook. Before submitting the ICR to OMB, the Coast Guard is inviting comments on it as described below.

DATES: Comments must reach the Coast Guard on or before July 26, 2005.

ADDRESSES: To make sure that your comments and related material do not enter the docket [USCG–2005–21202] more than once, please submit them by only one of the following means:

(1) By mail to the Docket Management Facility, U.S. Department of Transportation (DOT), room PL–401, 400 Seventh Street, SW., Washington, DC 20590–0001.

(2) By delivery to room PL–401 on the Plaza level of the Nessie Building, 400 Seventh Street, SW., Washington, DC, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9325.

(3) By fax to the Docket Management Facility at 202–493–2251.


The Docket Management Facility maintains the public docket for this notice. Comments and material received
DATE: May 23, 2005

TO: Judy Enright, ValueOptions

FROM: Carolyn Ingram, Director of Medical Assistance Division

SUBJECT: Letter of Direction: #3 Medicaid Fee-for-Service Prior Authorization Issues

This Letter of Direction is in response to queries received in a variety of forums from the Statewide Entity (SE) concerning prior authorization (PA) of behavioral health fee-for-service (FFS) Medicaid services.

Below please find current procedure for fee-for-service prior authorizations as a reference, followed by recommended changes in fee-for-service prior authorization procedures.

The SE is directed to use this information as historical background in developing an “open access” management of behavioral health FFS services consistent with the procedures currently used by the three Salud! managed care organizations.

A. Current Prior Authorization Policies

Psychiatric Unit in Acute Care Hospital

- A psychiatric hospital event requires PA from the current Utilization Review contractor Blue Cross/Blue Shield (BCBS).
- Stays in an inpatient Acute Care Hospital that are not in a psychiatric unit do not require PA, regardless of having a psychiatric diagnosis, as the service is considered a physical health service.
- “Awaiting Placement” days require approval when a recipient has been approved for a residential level of care but no beds are yet available.
- Professional services with an inpatient place-of-service code do NOT require PA. See “Outpatient Behavioral Health Professional Services”.
- The UB-92 form is used for billing.

Inpatient Free Standing Psychiatric Hospital

- Coverage is for children through age 20 only (no adult coverage)
- Hospital event requires PA from BCBS.

Access • Quality • Accountability
• “Awaiting Placement” days require approval when a recipient has been approved for residential level of care but no beds are yet available.
• Professional services with an inpatient place-of-service code do NOT require PA. See “Outpatient Behavioral Health Professional Services”.
• The UB-92 form is used for billing.

**Outpatient Acute Care Hospital, including Partial Hospitalization**
• Hospital event does NOT require PA. Costs for services by mid-level practitioners employed or contracted by the hospital are to be included in the hospital’s billed charges and no PA is required.
• Services by physicians or Ph.D. psychologists, or by mid-level practitioners not employed or contracted by the hospital are billed separately from the hospital claim and require PA from BCBS. See “Outpatient Behavioral Health Professional Services”.
• Hospital emergency room services do not require PA for the facility charge. Professional charges in the outpatient hospital setting (not included in the facility charge) are subject to the approval requirements under “Outpatient Behavioral Health Professional Services”, below.
• The UB-92 form is used for billing.

**Outpatient Free Standing Psych Hospital, including Partial Hospitalization**
• Coverage is for children through age 20 only (no adult coverage)
• Hospital stay does require PA from BCBS. Costs for services by mid-level practitioners employed or contracted by the hospital are to be included in the hospital’s billed charges and do not require a separate PA.
• Services by physicians or Ph.D. psychologists, or by mid-level practitioners not employed or contracted by the hospital are billed separately from the hospital claim and require PA. See “Outpatient Behavioral Health Professional Services”.
• All services provided by a Free Standing Psychiatric Hospital require PA, including Partial Hospitalization.
• The UB-92 is used for billing.

**Outpatient Behavioral Health Professional Services (psychiatrist, psychologist, LISW, LPCC, LMFT, and CNS certified in psychiatric nursing) including services in group practices and clinics and community mental health centers**
• Evaluation and treatment - three hours are allowed without PA (code 90801). Additional evaluation requires PA from BCBS. If a recipient goes to a different provider in a different group practice or clinic, three more hours are allowed without PA. The reason for this is that it is assumed the provider needs up to three initial hours to have enough information to request approval for further services. This also allows the recipient the option to choose a different provider if he/she wishes a second opinion or to change providers.
• Individual, family and group counseling and therapy all require PA from BCBS.
• No PA is required for up to 8 hours of psychological testing, codes 96100 and 96117. Additional testing requires PA from BCBS.
• Some additional mid-level practitioners other than those listed above (such as licensed master’s level social workers, licensed psychology associates, and licensed master’s level counselors) are allowed to provide services when rendered in a community mental health center. In this circumstance, PA is applied using the same rules as for other outpatient behavioral health professional services, as described in this section.
• The HCFA-1500 form is used for billing.

Accredited Residential Treatment Centers (ARTC), Residential treatment Centers (RTC), and Group Homes
• All children’s residential services require PA from the Children’s Mental Health Services Review Panel (“Clinical Care Unit” or “Children’s Panel”) of the Children, Youth and Families Department (CYFD) and are carried in Omnicaid, the MMIS (Medicaid managed care information system), as a Long Term Care Span indicating the level of care; not in the PA file.
• Services are not provided for persons over 20 years of age.
• Professional services are paid concurrently ONLY if they are not part of the rates or scope of services expected to be provided by the facility, or if there is special justification on the part of the provider (usually associated with admission or pending discharge) and also require PA from BCBS. See “Outpatient Behavioral Health Professional Services”.
• Medicaid provider types do not distinguish between non-accredited residential treatment center and group homes. The levels of care that are authorized for the group home may be more limited than that for a non-accredited residential treatment center.
• The UB-92 is used for billing.

Treatment Foster Care I and II (TFC I and TFC II)
• All TFC services require PA from the Children’s Panel, and are carried in the MMIS Omnicaid system as a Long Term Care Span indicating the level of care; not in the PA file.
• Services are not provided for persons over 20 years of age.
• Professional services are paid concurrently but require PA from BCBS. See “Outpatient Behavioral Health Professional Services”.
• The UB-92 is used for billing.

Day Treatment and Behavior Management Services
• Services require PA from the Children’s Panel.
• Services are not provided for persons over 20 years of age.
• The HCFA-1500 is used for billing.

School-based Services
• A service called for in an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP) may be billed by a school, and PA is not required. (A school is only allowed to bill for services in the IEP or IFSP.) Note that if the service is provided by a school-based clinic, (that is, a clinic provides the services but is not actually the school) refer to the type of clinic for the PA requirements, for example, an FQHC.
• The HCFA-1500 form is used for billing.
Psychosocial Rehabilitation (PSR)

- Services do not require PA, however PSR may be difficult to distinguish from non-PSR services when providers render both PSR and other behavioral health services, because PSR services are generally distinguished only by a modifier billed with the procedure code.
- Services are available only for individuals 18 years of age and older.
- The HCFA-1500 form is used for billing.

Case Management Services for Chronically Mentally Ill (CMI) or Severely Emotionally Disturbed (SED) recipients

- PA is not required. Services can be provided by either a case management agency or a facility provider.
- Services are not available concurrently with residential and inpatient services except during last 30 days of placement for the purpose of arranging community placement.
- The HCFA-1500 form is used for billing.

Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

- Technically, prior authorization is required for the same services described under outpatient mental health practitioners, above. However, because the information on the UB-92 form does not distinguish the services sufficiently, no PA has been enforced for these providers.
- The UB-92 form is used for billing.

Indian Health Service and Tribal 638 Contracts

- PA is not required for services billed on the UB-92 form, including outpatient behavioral health services, inpatient hospitalization and case management.
- PA is required for IHS ARTC/RTC services. IHS ARTC/RTC services are billed on the HCFA 1500.

General Information

- Professional services in an in-patient setting
  When a professional service is rendered in an “in-patient” setting, PA is not required. For the purposes of this definition, the following place-of-service codes are considered to be in-patient: 06-Indian Health Services Hospital, 08-Tribal Hospital, 21- Inpatient, 31-Skilled Nursing Facility, 32-Nursing Facility, 51-Inpatient Psychiatric Facility, 54-Intermediate Care Facility for the Mentally Retarded, and 61-Comprehensive Inpatient Rehabilitation Facility.

- Prior Authorization for prescription drug items
  PA is not required, whether a prescription is filled at a pharmacy, or an injectable medication is given by a physician or in a clinic. For dually eligible Medicare/Medicaid clients currently enrolled in NMRx, PA is required for “atypical antipsychotic agents” if the prescriber is not a psychiatrist or psychiatric clinical nurse specialist (CNS) or certified nurse practitioner (CNP), and the recipient has not been taking them in the past.
Pharmacy claims are submitted electronically utilizing a standard claim format developed by the National Council for Prescription Drug Programs (NCPDP). The Healthcare Common Procedure Coding System (HCPC) codes that begin with J and are administered in an office or clinic are billed on the Health Insurance Claim Forms 1500 (HCFA-1500). Injections administered in a hospital outpatient or emergency room setting are billed on a Universal Billing form (UB-92).

- **Prior Authorization in cases of emergency or crisis situations**
  In cases of emergency or crisis situations, retroactive approval will be given when the criteria are otherwise met. Prior authorization is not needed at the time of service.

- **Medicaid eligibility after a service has been provided**
  In cases where a provider learned after the fact of the Medicaid eligibility of the recipient, retroactive approval will be given when the criteria are otherwise met, and the circumstances for not receiving approval in advance is justifiable.

- **M0064**
  Code M0064, "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders," does not require PA.

- **Medicare/Medicaid crossovers**
  Payment of Medicare co-insurance and deductible amounts (not part of VO’s responsibility), do not require PA.

B. **The Medical Assistance Division is proposing that the SE use an “open access” approach that has been implemented in the current Salud! program for the management of the Medicaid fee-for-service program. The following areas are recommended for change to not include prior authorization**

- Outpatient behavioral health professional services (psychiatrist, psychologist, LISW, LPCC, LMFT and CNS certified in psychiatric nursing) including services in group practices and clinics and community mental health centers.
- Day Treatment and Behavior Management Services.

C. **Current Prior Authorization Contractors**

CYFD’s Children’s Panel conducts reviews of Medicaid residential services for children. ‘Children’ in Medicaid are defined as recipients through the age of 20.

The Children’s Panel is currently responsible for:

- Accredited Residential Treatment Centers
- Residential Treatment Centers/ Group Homes
- Treatment Foster Care I and II
- Day Treatment
• Behavior Management Services

All other prior authorizations are determined by the Blue Cross/Blue Shield utilization review team.

D. What will happen to BCBS and the Children’s Panel on July 1, 2005?

• BCBS will no longer conduct any utilization review for prior authorization for behavioral health FFS services. Patrick Halsmer of Human Services Department will be available as a prior authorization ‘consultant’ for ValueOptions, to assist with transition issues.
• The Children’s Panel will no longer conduct any utilization review for prior authorization of behavioral health FFS services. Connie Romero of CYFD and her staff will be available as prior authorization ‘consultants’ for ValueOptions to assist with transition issues.
• ACS, the Medicaid FFS fiscal agent, maintains an authorization record and the quantity of services already rendered under each authorization.

E. What can be expected in regards to future standardization of prior authorization review protocol for Medicaid fee-for-service and Medicaid Salud!?

• When an authorization given previously extends past July 1, 2005, the SE is expected to honor that authorization for 30 days or until it expires.
DATE: June 24, 2005

TO: Pam Galbraith, CEO, ValueOptions

FROM: Carolyn Ingram, Director of Medical Assistance Division

SUBJECT: Letter of Direction #4, Regarding Medicaid Covered Services

Over the next few months Medicaid will be working with a variety of stakeholders to review Medicaid reimbursement policies for accredited and non-accredited residential treatment centers and group homes.

In the interim, Medicaid reimbursement for both Coordinated Services (FFS) and managed care for the identified residential levels of care noted above will be reimbursed at a per diem rate. The rates are identified in the managed care and coordinated services (FFS) rate schedules developed by VO and reviewed by HSD.

Please contact Leslie Tremaine at (505)827-1344, Behavioral Health Contract Manager if you have further questions.
TO: ValueOptions of New Mexico

FROM: Matthew Onstott, Collaborative Oversight Team

DATE: March 28, 2006

SUBJECT: LETTER OF DIRECTION # 6
PRIOR AUTHORIZATIONS: REDUCTIONS AND TERMINATIONS OF CARE

This LOD clarifies the Oversight Team and VO jointly agreed upon modification to the prior authorization process for certain behavioral health services.

The agreed upon modifications are as follows:

- Reductions of Care
  - In submitting a request for a prior authorization, providers will request a specific level of care from the behavioral health Statewide Entity (SE); however, the provider will not request a specific number of units and/or days of service. The SE utilization management staff shall authorize the amount of units or hours that are indicated by the consumer’s clinical presentation and treatment plan.

- Terminations of Care
  - In the event that a consumer leaves a level of care prior to the authorization time span, either by choice or in agreement with the provider, the SE is not required to send an “action” letter to the consumer notifying them of the termination of care. The SE is required to send an “action” letter when the decision to terminate the care is made by the SE.

Definitions:

Reduction of Care (Per HSD Medicaid Managed Care regulation 8.305.1.7 R(3)): A utilization management staff authorization of the type of service requested by the provider but in lesser amounts or units of service than were originally requested. The authorization is based on the client’s physical health (medical needs) or behavioral health (clinical needs).

Termination of Care (Per HSD Medicaid Managed Care regulation 8.305.1.7 T(1)): The utilization management review decision made during a concurrent review, which yields a denial based on the current services being no longer medically necessary.
Date: August 16, 2006

To: Pam Galbraith, CEO
ValueOptions

From: Matthew Onstott, Division Director
Medical Assistance Division

RE: Letter of Direction #7
SFY 2007 Data Certification

This Letter of Direction (LOD) identifies regulation language impacting reporting requirement for managed care. The effective date for implementation of the new changes is July 1, 2006.

Requirement for Data Certification (42 CFR 438.606; 42 CFR 438.608): The data that shall be certified include, but are not limited to, all documents specified by HSD/MAD, enrollment information, encounter data and other information contained in contracts or proposals. The documents shall be certified by: 1) The SE’s Chief Executive Officer; 2) the SE’s Chief Financial officer; or 3) an individual who has delegated authority to sign for, and who reports directly to the SE’s Chief Executive Officer or Chief Financial Officer. The certification shall attest, based on best knowledge, information and belief as to the accuracy, completeness and truthfulness of the documents and data. The SE shall submit the certification concurrently with the certified data and documents. The SE shall identify within their organizations those individual(s) with authority to perform data certification as required by CMS and notify HSD/MAD by the effective date of this LOD. HSD/MAD reserves the right to require certification of data/reports not listed below.

The following is the list of reports that will require certification:

HSD BH Specific Reports
Monthly
HSD 7 Withholding Bank Statement

Quarterly
HSD 8 Cash Reserve Bank Statements
HSD 10 Behavioral Health Expenditure by Category
HSD 11 FQHC/RHC Payment Report (Check Register)
HSD 12 Payments to IHS, Tribal 638 and Providers
HSD 13 Stop Loss Protection
HSD 14 Department of Insurance Quarterly Statements
HSD 15 Medicaid Specific Financial Statements
Annual Reports
HSD 16 Fidelity Bond Insurance
HSD 17 Reinsurance Policy
HSD 18 Risk Withholding
HSD 19 Independent Audited financial Statements
HSD 20 Medicaid Specific Audited Schedule of Revenue & Expenses
HSD 21 Department of Insurance Annual Statement

Collaborative Reports (see note)
Critical Indicator Reports
CI-06A Provider Payment Timeliness Report
CI-09 Services Utilization Report
CI-10 Administrative vs. Direct Services Costs Report
CI-11 Independently Audited Financial Statements (MC) Report

- NOTE:
  - For Collaborative reports, only HSD data needs to be certified.
  - Reports requested “Ad Hoc” (such as HSD5 Third Party Liability or HSD6 Coordination of Benefits) must be certified.
  - Enrollment data do not require certification unless differences are identified when compared to the data provided by HSD/MAD.
Date: August 16, 2007

To: Pam Galbraith, CEO
ValueOptions

From: Matthew Onstott, Deputy Director
Oversight Team Lead
Medical Assistance Division

RE: Letter of Direction #8 REVISED - FY 2008 Notification of Change, Closure & Transition Plans

This Letter of Direction (LOD) provides clarification for the Statewide Entity (SE) regarding the Notification, Closure and Transition Plan requirements as required by State Agencies and identified in the contract (FY08).

- Article 5.3
  - The SE shall notify the Collaborative within five (5) business days of unexpected changes to the composition of its provider network that would have a significantly negative affect on consumers or on the SE’s ability to deliver services included in the benefit package in a timely manner.

  Providers are required to give at least thirty (30) days notice of any intent to diminish, materially change, or substantially reduce services.

- Article 5.3
  - Anticipated material changes in the SE provider network shall be reported to the Contract Manager in writing within thirty (30) days prior to the change, or as soon as the SE knows of the anticipated change. A notice of significant change must contain
    1. the nature of the change;
    2. how the change affects delivery of or access to covered services; and
    3. the SE’s plan for maintaining access and the quality of consumer care.

The SE is required to submit Notification, Narrative and Transition Plans A and B to the designated Collaborative Oversight contact person whenever a provider informs the SE of its intent to change or terminate a service(s) and consumers need to transition from one service provider to another or, a service provider becomes incapable of performing a contracted service. In all instances, the SE is expected to report, in the provided narrative format, how the changes will affect the service delivery system.

For both expected and unexpected changes in the network, the SE shall assess the significance of the change or closure within ten (10) calendar days of a confirmation by
the provider. If the SE determines the change will not have a significant impact on the system, the Narrative must be submitted within ten (10) calendar days from the date of notification of change or closure to the Collaborative. The SE must explain in the Narrative all factors considered in making the determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable). If the SE determines the change or closure will significantly impact the delivery system, The SE is required to submit Transition Plan A (Overall), Transition Plan B (Client Specific) and the Narrative to the Collaborative within fifteen (15) calendar days of official notification to the Collaborative. In the event that the Collaborative determines a network change is significant, the SE will be required to submit all transition information as requested.

Transition information will be submitted on the attached templates with all columns completed. The Narrative will be submitted in text format, unless otherwise specified. Updates will be submitted every other week after the initial submission. A final update will be submitted upon closure or completion of the change in service(s). The Notification, Narrative and Transition Plan A will be submitted via email to the designated Collaborative Oversight contact person. Transition Plan B will be submitted by fax if the number of consumers transitioning is 150 or less. If the number of consumers being transitioned is over 150, Transition Plan B will be submitted on a CD to the designated Collaborative Oversight contact person. VO must request an extension for the submission of required Transition Plans from the Collaborative Oversight contact person if the above timelines cannot be met.

**Notification**

The Notification will include the following information:

- Date
- Name of Provider or Facility
- Type of Service
- Region
- Location/City of Office(s)/Facility Closing
- Total Number of Consumers Affected and Number of Consumers <21 and >21
- Nature of the Change
- Anticipated Date of Closure
- Transition Plans Required?
- Narrative Due Date

If the SE determines transition plans will be required, then Notification will also include the following information:

- Date VONM Notified of Closure
- Narrative, Transition Plan A and Transition Plan B due dates
- Name of VONM Regional Director Responsible for Transition

**Narrative:**

The Narrative will include information regarding:

- How the change affects delivery of, or access to, covered services
- The SE’s plan for maintaining access and the quality of consumer care
- Factors considered in making the determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable)
- Transition Issues Identified

8.7.07
Transition Plan A—Overall Transition Template
The Overall Transition Plan will include information regarding:
- Preplanning
- Network Operations
- Transition Planning
- Oversight communication
- Regional Care Coordination
- Other requirements as needed depending on circumstances of closing

Transition Plan B—Client Specific Template
The Client Specific Transition Plan will include information regarding:
- Client name
- Social Security Number
- Date of Birth
- Guardian (if applicable)
- Services currently receiving
- Current Provider
- Funding Stream
- Date of discharge (if applicable)
- New Provider (or anticipated new provider)
- Date of transition or anticipated date
- 1st Appointment date (for outpatient services)
- VO Specialized Care Coordinator/Field Care Coordinator and phone number
- Special Conditions/Arrangements/Comments (i.e., co-managed, coordination efforts to date, barriers to transition, etc.)
- MCO notified? (if applicable)
- JPPO/CYFD SW notified? (if applicable)

Attachments:
- Notification template
- Narrative template
- Transition Plan A template
- Transition Plan B template
## Notification of Closure/Transition Form

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Name of Provider or Facility</td>
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<tr>
<td>2</td>
<td>Type of Service</td>
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<tr>
<td>3</td>
<td>Region/VONM Regional Director and Phone Number</td>
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<tr>
<td>4</td>
<td>Location/City</td>
</tr>
<tr>
<td>5</td>
<td>Date Provider Notified VONM</td>
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<td>6</td>
<td>Anticipated Date of Closure</td>
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<td>7</td>
<td>Total Number of Consumers</td>
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<td>8</td>
<td>Number of Consumer Under 21</td>
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<td>9</td>
<td>Number of Consumer Over 21</td>
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<td>10</td>
<td>Narrative Due Dates</td>
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<tr>
<td>11</td>
<td>Transition Plan A (Overall) Due Dates</td>
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<tr>
<td>12</td>
<td>Transition Plan B (Client Specific) Due Dates</td>
</tr>
<tr>
<td>13</td>
<td>Anticipated Change (YES/NO)</td>
</tr>
<tr>
<td>14</td>
<td>Unanticipated Change (YES/NO)</td>
</tr>
</tbody>
</table>
Narrative template

Narrative
For

(Provider/Facility Name)

VONM Regional Director:
Date:

Describe the reason(s)/circumstance(s) and any contributing factors to the change or closure:

How the change affects delivery of, or access to, covered services (describe how the change impacts the system as whole and at the regional level):

The SE’s plan for maintaining access and the quality of consumer care:
**Narrative template**

Please explain all factors considered in making the determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable).

<table>
<thead>
<tr>
<th>Transition issues identified</th>
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</table>
## Transition Plan A

### VONM Transition Plan For
(Provider Name)
(Date)

<table>
<thead>
<tr>
<th>VONM task assignment</th>
<th>Comments</th>
<th>Begin Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>1. Preplanning</td>
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<tr>
<td>A. VONM receives communication that program is closing</td>
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<td>B. Closing program sends a formal letter to VONM advising of closing</td>
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<td>C. List of affected consumers sent to VONM</td>
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<td>D. List of special problems expected or associated with transition</td>
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<tr>
<td>E. VONM letter to affected consumers offering assistance (as needed)</td>
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<tr>
<td>A. Notify Network operations and assist with contracting affected providers</td>
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<tr>
<td>B. Contracting completed as needed</td>
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<td>3. Transition planning</td>
<td></td>
<td></td>
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<tr>
<td>A. Meeting with program or Director</td>
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</table>
## TRANSITION PLAN A

<table>
<thead>
<tr>
<th>VONM task assignment</th>
<th>Comments</th>
<th>Begin Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>B. Complete plan to ensure the program is appropriately referring and transitioning affected consumers.</td>
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<tr>
<td>C. Progress updates of transition program</td>
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</table>

### 3. Oversight Communication

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
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<tbody>
<tr>
<td>A.</td>
<td>Submit Notification</td>
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<tr>
<td>B.</td>
<td>Submit narrative</td>
</tr>
<tr>
<td>C.</td>
<td>Submit Transition Plan A</td>
</tr>
<tr>
<td>D.</td>
<td>Submit Transition Plan B</td>
</tr>
<tr>
<td>E.</td>
<td>Bi-weekly updates of transition plans and narrative from VONM to state agency contact person</td>
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</table>

### 4. Regional Care Coordination

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
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<tbody>
<tr>
<td>A.</td>
<td>Identify regional field care managers (FCM) to be contact point for consumers seeking assistance</td>
</tr>
<tr>
<td>B.</td>
<td>FCM review community resources</td>
</tr>
<tr>
<td>C.</td>
<td>Coordinate FCM and VONM Clinical Department tasks</td>
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<tr>
<td>D.</td>
<td>Compile weekly report of care coordination</td>
</tr>
<tr>
<td>E.</td>
<td>Coordinate with VONM Recovery and Resilience to assist consumers</td>
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### TRANSITION PLAN A

<table>
<thead>
<tr>
<th>VONM task assignment</th>
<th>Comments</th>
<th>Begin Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>F. Meeting with VONM and program transition team to coordinate efforts</td>
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<td>5. Other requirements as needed depending on circumstances of closing</td>
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<tr>
<td>Client Name</td>
<td>Social Security Number</td>
<td>Date of Birth</td>
<td>Guardian (if applicable)</td>
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DATE: September 12, 2006

TO: Pamela Galbraith, CEO
ValueOptions of New Mexico

FROM: Matthew Onstott, Deputy Director
Medical Assistance Division, HSD
Collaborative Oversight Team Lead

RE: Letter of Direction #9
Comprehensive Community Support Services (CCSS) Codes and Services that will be replaced by CCSS

This Letter of Direction (LOD) identifies for Value Options the services that will be replaced by Comprehensive Community Support Services (CCSS) as well as the codes to be replaced and the new service code to be implemented. This LOD also identifies the agencies whose services will be replaced with CCSS.

1) The codes that will change as a result of the implementation of CCSS are as follows:
   a) Human Service Department (HSD) Fee for Service and Managed Care programs:
      i) The targeted case management services for Medically at Risk (SED) and the Chronically Mentally Ill (CMI) billed utilizing the codes/modifiers T1017 HK and T1017 HE will be deleted. Medicaid does not pay for this code without a modifier.
      ii) This also applies to the targeted case management services provided through IHS and Tribal 638 programs.

   b) Department of Health (DOH) and the Children, Youth and Families Department (CYFD):
      i) All case management services billed through code T1016 will be deleted.

   c) HSD and DOH:
      i) INDIVIDUAL Psychosocial Rehabilitation Services (PSR) provided to adults funded by using the code H2017 will be deleted.

   d) CYFD:
      i) Individual Life Skills services using the same H2017 code will also be deleted.

2) Codes that will continue to be used are as follows:
   a) HSD and DOH:
      i) The code H2017 HQ, for GROUPS, will continue to be used for PSR.

   b) CYFD:
      i) The H2017 HQ will continue to be used for CYFD LIFE SKILLS GROUPS and require a HA modifier in addition to the HQ modifier.
- New Mexico Corrections Department (NMCD):
  - The T1016 code (with specific modifiers) will continue to be used by NMCD. The title of these services shall be "Resource Management."
  - NMCD will use the code H2017.
- HSD Managed Care:
  - School-based "enhanced" services: The T1016 TR code will continue to be used for the School-based health centers "enhanced" services.
DATE: January 31, 2008

TO: Mary Mastrandrea, Acting CEO
    Value Options New Mexico

FROM: Bill Belzner, Deputy CEO
      BH Purchasing Collaborative

RE: Letter of Direction #9 (Addendum)
    Comprehensive Community Support Services (CCSS) Codes and Services

This Letter of Direction (LOD) provides clarification of the use of codes and rates specifically for the IHS and 638 Tribal facilities contracted by VO for Medicaid services. This addendum to LOD #9 only replaces the coding and rate for IHS and 638 facilities as noted below.

In order for HSD and VO to track CCSS services for IHS and 638 Tribal facilities, the Collaborative requests that VO require IHS facilities to bill using the HCPC Code for CCSS – H2016 and requires that the provider also use one of the three modifiers for the different level of practitioners as identified in LOD #9. In addition to IHS and 638 facilities using a different code, the reimbursement rate for their services will be at the IHS all-inclusive outpatient (OMB), rate, per session. IHS and 638 Tribal facilities should bill for CCSS services on a CMS 1500 claim form.

As stated above, the outpatient rate will be paid per session, which translates into a flat rate per day. For example, if an IHS facility bills CCSS for 4 sessions of CCSS in one day, IHS would only be paid the flat OMB rate of $256.00 for that day.

If you have any questions, please feel free to contact Shari Roanhorse-Aguilar, Native American Liaison, HSD/MAD at 827-3133.
To: Pamela Galbraith, CEO, Value Options of New Mexico
From: Matthew Onstott, Oversight Team Lead
Date: December 8, 2006
RE: Letter of Direction # 10
Clarifications to:
- NCQA Requirements
- Clinical Tracking Measures
- Program Integrity/Fraud & Abuse
- Disease Management

This Letter of Direction (LOD) is provided to define and clarify the terms of the Value Options of New Mexico Contract effective July 1, 2005 and Value Options of New Mexico Contract effective July 1, 2006, related to Quality Assurance reporting and submission requirements. This contractual requirement will remain in effect until notification is given by the Collaborative or unless the contract is terminated with the SE.

NCQA Requirements

The Collaborative/Oversight Team acknowledges that there is no contract requirement for the Statewide Entity (VO) to be NCQA accredited or to participate in an annual HEDIS audit of reported measurement data.

Although New Mexico specifications for VO reports may reflect approved national methodologies, the results are not comparable to HEDIS, or to HEDIS-audited data.

Clinical Tracking Measures

Per Contract Article 5.6.C.6, the SE’s QM/QI functions shall include conducting data-driven evaluations of clinical practices to improve quality of care. VO shall follow the specifications for each measure, detailed in Guidance Memo (GM) HSD-23.

- Antidepressant Medication Management;
- ADHD Medication Management in Children;
- Mental Health Utilization: Inpatient Discharges and Average Length of Stay;
- Mental Health Utilization: Percentage of Members Receiving Inpatient and Intermediate Care and Ambulatory Services.
**Program Integrity/Fraud & Abuse**

The Collaborative has developed the following guidance and directives related to program integrity/fraud & abuse, in accordance with the mandatory program integrity/fraud & abuse requirements established by the Code of Federal Regulations, the Deficit Reduction Act (DRA) of 2005 and the Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Program (MIP).

1. Provider Profiling/Exception Reports and Investigations – VO shall create exception reports on at least one provider type, subtype, billing code, or service. This report is used to detect over or underutilization of services (ex. An individual provider’s procedure coding is contrasted with the procedure coding patterns for similar providers within the same Specialty).
   - Provider Profiling/Exception data must be completed and compiled monthly and submitted to the Collaborative quarterly. Reports are due within 30 days of the end of each quarter.

2. Suspicious Activity Reporting to the Collaborative – VO is required to report “suspicious activity” to the Collaborative. The law requires only that VO suspect fraud; therefore VO is not required to conduct a full investigation. A referral to the Collaborative does not mean that the referral will result in prosecution.

3. Fraud and Abuse Training – VO shall provide program integrity/fraud & abuse detection and control training to all new employees, and "refresher" training to all current employees on a yearly basis.

4. VO must comply with Section 6032 of the DRA, including:
   - Develop and implement written policies for all employees that provide detailed information in relation to:
     a. False Claims Act;
     b. Administrative remedies for false claims and statements;
     c. Whistleblower protections under such laws.
   - Include in any employee handbook for VO as specific discussion of the laws described in Section 6032 (A), the rights of employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting fraud, waste, and abuse.

5. VO shall provide a copy of all materials used for program integrity/fraud & abuse training, written policies related to the DRA and applicable section of the employee handbook(s) to the Collaborative for review/approval annually. The Collaborative will complete review/approval within thirty (30) days of submission and notify VO accordingly.

6. Through the Medicaid Integrity Program (MIP), CMS has identified areas of the Medicaid program that are most vulnerable to fraud, waste and
abuse. The Collaborative encourages VO to target programmatic vulnerabilities identified and discussed within the MIP when developing their work plans and anti-fraud programs. The Comprehensive Medicaid Integrity Plan can be found at: www.cms.hhs.gov/DeficitReductionAct/02_CMIP.asp

Disease Management Program –Article 5.6 SFY 2006 Contract:

VO is to implement a Disease Management program (Article 5.6.1.1). The Collaborative directs VO to focus on Depression as a single Disease Management initiative. VO shall design a comprehensive Disease Management program for Depression based on VO analysis of their member enrollment, demographics, and cost benefit. This program must encompass pediatric, adolescent, post-partum, and adult depression as it manifests in multiple clinical settings. The program will be in accordance with the behavioral health initiatives as defined by the New Mexico Behavioral Health Collaborative (Goal 4); the HSD Secretary’s defined goals; and the President’s Commission on Mental Health (also Goal 4).

The Disease Management comprehensive plan description for a Depression Disease Management program should be incorporated into VO’s annual Quality Management/Quality Improvement plan and submitted to the Collaborative/Oversight Team for review and approval. The comprehensive plan description shall include the following nationally recognized components: population identification/stratification process, collaborative practice models, patient self-management education process, evidence-based practice guidelines, process and outcomes measurements, and internal quality improvement processes.

An effective disease management program should be able to demonstrate identification and participation of, and benefit to, members enrolled in the disease management program. Thus, VO shall develop methodology to track the efficacy of its interventions and outcomes for its disease management program for Depression.