Section 1915(b) Waiver
Renewal For
MCO, PIHP, PAHP, PCCM Programs
And
Behavioral Health Programs

March 30, 2007
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Renewal for a Section 1915(b) Waiver
MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The State of New Mexico requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is _The New Mexico Behavioral Health Waiver_. (Please list each program name if the waiver authorizes more than one program.).

Type of request. This is an:
___initial request for new waiver. All sections are filled.
___amendment request for existing waiver, which modifies Section/Part Sections A-D

___Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

___Document is replaced in full, with changes highlighted

_X__ renewal request

___This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.

_X__ The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

Section A is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Program Description from the previous waiver period.

_X__ assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is ___ replaced in full

___ carried over from previous waiver period. The State:

___ assures there are no changes in the Monitoring Plan from the previous waiver period.

_X__ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages.
**Effective Dates:** This waiver is requested for a period of two (2) years; effective 07/01/07 and ending 06/30/09. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date.)

**State Contact:** The State contact person for this waiver is Carolyn Ingram and she can be reached by telephone at (505) 827-3106 or fax at (505)827-3185, or e-mail at Carolyn.Ingram@state.nm.us. (Please list for each program)
Section A: Program Description

Part I: Program Overview

The NM Human Services Department, Medicaid (the Department) is in the second year of implementation of a new “carved-out” statewide system for behavioral health (BH). As mandated by New Mexico House Bill 271 in 2004, the Interagency Behavioral Health Purchasing Collaborative (hereafter referred to as the Collaborative) was established, and a single statewide entity (SE) selected to create an integrated behavioral health service delivery system. In consolidating the services, funds, and administrative functions across the multiple State agency members of the Collaborative, including the Department, the goal was to build a cost-efficient, coordinated, accessible and effective statewide system for the provision of BH services. The Department is submitting this waiver renewal application in the hope that it may continue to build and refine this new system together with its Collaborative partners.

Since initiation of the new system on July 1, 2005, the Department, the seventeen other State agency Collaborative members, and the single statewide entity, ValueOptions New Mexico, have successfully established the critical elements of the new state-wide system. Most significantly, these include a statewide network of behavioral health providers, a process for eligibility determination and enrollment, a utilization and quality management system, a process for consumer and family involvement, a system of evidence-based practices, a grievance and incident management system, and a reporting system that tracks the fulfillment of agency specific as well as Collaborative contractual obligations. It must be noted that while maximizing efficiency by contracting with a single administrative body, the Department has preserved accountability for Medicaid specific requirements, regulations and funding, and ensured provision of the full Medicaid BH benefit package to Medicaid beneficiaries in New Mexico.

Tribal Consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

New Mexico is home to twenty-two federally recognized Indian Tribes and Pueblos, and has the fifth largest Native American population of any state in the nation, including nineteen pueblos, two Apache tribes, and part of the Navajo Nation. In proportion to other racial and ethnic groups in New Mexico, Native Americans have significant behavioral health needs, including a high rate of substance abuse, alcohol-related morbidity and mortality, and suicide.

The Department and the Collaborative recognize the unique behavioral health care needs of the Native American population and have worked aggressively to include Native American leaders and stakeholders in all stages of the planning and implementation of the new BH system. In an attempt to maximize representation of Native Americans and Native American interests in the new system, such interests have been formally integrated into the organizational structure, i.e., one of the SE Regional Offices (Region 6) and two of the fifteen Local Collaboratives (LCs) has
been specifically identified “for Native American Tribes or Pueblos.” These entities are
designed to provide mutual advice and consultation relative to service delivery issues. To
further ensure a responsive and effective BH system for Native American individuals, the
following requirements were incorporated in the Collaborative contract with the SE:

- The SE shall acknowledge and honor Native American Tribes, Nations, and Pueblos as
  inherently sovereign nations on and off their Tribal, Nation, or Pueblo lands.
- The SE shall design, implement and maintain culturally and linguistically appropriate
  services and supports for members of the New Mexico-based Indian Tribes, Nations, and
  Pueblos and other Native Americans.
- The SE shall work with appropriate Tribal, Nation, and Pueblo communities and their
  programs on providing behavioral health services, including substance abuse and mental
  health issues.
- The SE shall respect and respond appropriately to the inherent sovereignty of Native
  American Tribes, Nations, and Pueblos in planning or changing service delivery and
  evaluation.
- The SE shall be flexible and considerate in meeting the needs of Native Americans
  throughout the State.
- The SE shall seek, incorporate and utilize the views of Native American stakeholders
  (consumers and family members; BHPC Native American Subcommittee; providers; Tribal,
  Nation, and Pueblo leaders; and advocates) in the design and implementation of the
  behavioral health service delivery system and in making modifications to the system for
  improvements.
- The SE shall promote and utilize culturally and linguistically appropriate traditional healing
  services for Native Americans while maintaining sensitivity to the unique perspectives of
  the various Tribes, Nations, and Pueblos that may prefer to limit their participation because
  of cultural beliefs and to keep religious practices safeguarded.
- The SE shall provide and strengthen its organizational structures that respect the unique
government-to-government relationships of the State and the Native American Tribes,
Nations, and Pueblos, which also recognizes the unique system of the Indian Health Service
(IHS), for purposes of collaborating, cooperating, and communicating with each other.
- The SE shall provide for appropriate personnel for purposes of accessing and delivering
  behavioral health services and as direct liaisons with the 22 Native American Tribes,
  Nations, and Pueblos, Indian Health Service (IHS), LCs, and other tribal entities.
- The SE shall hire staff who have experience with Native American behavioral health issues
  and New Mexico tribal communities to work specifically with Tribal, Nation, or Pueblo
  communities and providers who serve Native Americans to create, strengthen, support, and
  provide assistance to the LC(s) in Region 6 and any Urban Native Americans throughout
  the State. At least one full-time SE staff person shall be dedicated to working on Native
  American issues.
- Subject to available funding, the SE shall preserve the current reimbursement system for
  Native Americans with the goal of preserving services and specific programming for Native
  Americans.
• The SE shall maintain contracts with IHS of Albuquerque and Navajo Area IHS and with 638, Tribal, Nation, Pueblo and Urban Indian behavioral health providers that meet minimal credentialing requirements for service delivery within New Mexico who want to contract with the SE.

• The SE shall ensure that linkages with Tribal, Nation, and Pueblo Courts; IHS; Bureau of Indian Affairs (BIA); and Tribal, Nation, or Pueblo 638 programs are developed at the SE level and shall ensure that its subcontracted providers have established linkages with the preceding agencies in order to ensure appropriate coordination of care for Native American consumers utilizing those programs.

• The SE shall provide technical assistance upon request. Further, the SE shall provide training for billing, credentialing standards, benefits and services, and quality of care to IHS, Tribal, Nation, Pueblo and Urban Indian behavioral health providers following any major program changes or at the Collaborative’s request, but no less than two (2) times a year.

• The SE shall establish professional relationships with Native American programs statewide that provide behavioral health services and shall document the contacts.

• The SE shall refer Native American consumers to Native American programs to the extent possible, so that consumers’ needs may be assessed and met through culturally relevant Native American treatment services, unless a consumer requests otherwise.

• The SE shall provide services through its providers to Native American consumers when appropriate except where a consumer requests otherwise.

• The SE shall ensure that alternative/traditional healing services (i.e., traditional healers, sweat lodges, ceremonies, acupuncture, etc.) provided through Native American programs continue and/or are developed as appropriate.

• The SE shall show good faith effort to work with Tribal, Nation, and Pueblo judges and courts regarding tribal members.

• The SE shall make good faith efforts to work with schools, whether public, Tribal, Nation, Pueblo, or federal, regarding behavioral health care for Native American consumers and their families. The SE shall provide a quarterly written report to the Collaborative, the co-chairs of the Behavioral Health Planning Council (BHPC), and the chair of the BHPC Native American Subcommittee on the progress of the Region 6 office, implementing the activities identified above, or the plans to implement those activities.

Currently, Native Americans are served by each of the Collaborative member agencies and related funding as administered by the SE. In at least one case, funding is set aside specifically for programs serving Native Americans. The Collaborative is committed to preserving this set aside and ensuring that at least no fewer than the number previously served will continue to be served by the new system.

**Program History**

In September, 2003, Governor Bill Richardson directed all New Mexico State agencies tasked with the delivery, funding or oversight of behavioral health care services, including mental health and substance abuse services and treatment, to work collaboratively to create a single
statewide behavioral health service delivery system. With a combination of tight government budgets, a fragmented behavioral health system, and a growing demand for coordinated services, the time was right to pursue an improved behavioral health care delivery system. The Governor’s mandate came to fruition during the 2004 State Legislative session where House Bill 271 was introduced, passed and signed into law, effective May, 2004. The new law created an Interagency Behavioral Health Purchasing Collaborative, consisting of the secretaries or directors of the following State departments and agencies:

- Aging and Long-Term Services Department (ALTSD)
- Administrative Office of the Courts (AOC)
- Children, Youth and Families Department (CYFD)
- Corrections Department (NMCD)
- Department of Finance and Administration (DFA)
- Department of Health (DOH)
- Department of Labor (DOL)
- Department of Transportation (DOT)
- Developmental Disabilities Planning Council (DDPC)
- Division of Vocational Rehabilitation (DVR)
- Governor’s Commission on Disability (GCD)
- Governor’s Health Policy Coordinator (GHPC)
- Health Policy Commission (HPC)
- Human Services Department (HSD)
- Indian Affairs Department (IAD)
- Mortgage Finance Authority (MFA)
- Public Education Department (PED)
- State Public Defender’s Office

As per House Bill 271, the Collaborative was charged with:

- Inventoring all expenditures for mental health and substance abuse services;
- Creating a single behavioral health care and service delivery system that promotes mental health, emphasizes prevention, early intervention, resiliency, recovery and rehabilitation, that ensures availability of services throughout the state, and ensures the efficient management of funds;
- Paying special attention to regional, cultural, rural, frontier, urban and border issues, and seeking and considering suggestions of Native Americans;
- Contracting with a single, Statewide services purchasing entity (SE);
- Monitoring service capacities and utilization in order to achieve desired performance measures and outcomes;
- Making decisions regarding funds, interdepartmental staff, grant writing and grants management;
- Comprehensive planning and meeting State and federal requirements;
- Overseeing systems of care, data management, performance and outcome indicators, rate setting, services definitions, considering consumer, family and citizen input, monitoring training, assuring that evidence-based practices receive priority, and providing oversight for fraud and abuse and licensing and certification.
On November 3, 2004, the Collaborative released its Request for Proposals for a single statewide contractor to establish and administer a new behavioral health delivery system throughout New Mexico. As noted in the RFP, the new system was designed to address the following issues:

- Often insufficient and inappropriate services, especially a lack of attention to evidence-based and promising practices, and a workforce not focused on delivery of such practices;
- Lack of common agreement about goals and outcomes with an insufficient focus on recovery and resiliency;
- Not maximizing resources across funding streams;
- Multiple disconnected advisory groups and processes working toward different, sometimes disconnected goals;
- Fragmentation as described in the President’s New Freedom Commission report, that is, multiple service delivery approaches, plans, service definitions, billing processes, and reporting requirements for similar or related services;
- Duplication of effort and infrastructures at state and local levels, resulting in confusion for consumers, families, referral sources and providers;
- Higher administrative costs for providers due to multiple State approaches and multiple contracting entities or intermediaries;
- Insufficient or duplicative oversight of providers and services.

With the selection of ValueOptions New Mexico as the single statewide entity, the Collaborative initiated its new BH system on July 1, 2005. It should be noted that until that date, the statewide Medicaid Managed Care system, Salud!, established in July, 1997, provided both physical and behavioral health services. In spite of the demonstrated effectiveness and success of this coordinated model, it was determined that a carve-out of behavioral health services from the larger Medicaid Managed Care system would best permit the Collaborative to address the issues noted above. Since July, 2005, ValueOptions and the Collaborative have successfully established all the necessary elements of the new state-wide system and also accomplished the following:

- Development and establishment of Local Collaboratives organized around each Judicial District as well as Native American tribes, nations and pueblos
- Implementation of Standardized Service Definitions
- Establishment of a 24 hour suicide prevention hotline
- Establishment of Consumer/Family Advisory Boards state-wide
- Receipt of the Mental Health Transformation State Incentive Grant by SAMHSA.
- Development of Comprehensive Community Support Services (CCSS)
- Development of 21 Governor’s Performance Measures
- Establishment of Agency Specific and Collaborative reports
- Implementation of the Telehealth Pilot Project
- Hired a Communications Coordinator for the Collaborative

The new BH system as initially conceptualized by Governor Richardson in 2003, articulated in House Bill 271, and implemented by the Collaborative, is the product of much hard work by
numerous groups. An early impetus came with publication of the document “Behavioral Health Needs and Gaps in New Mexico” in July, 2002. This comprehensive analysis, conducted by the Technical Assistance Collaborative, Inc., provided for the first time a thoroughly researched review of the problems and recommended solutions for consideration by all interested parties across the state. The Behavioral Health Design Workgroup, a cross-agency group including six subcommittees, was created in the fall of 2003 to advise the Governor and subsequently the Collaborative in the design of the new BH system. The group worked for a full year, with extensive public input, in preparation of its recommendations which were published in the Draft Implementation Plan in July, 2004, and incorporated into the RFP released in November of the same year. Long-standing advisory groups such as the Behavioral Health Steering Committee, Children’s Advisory Task Force, DD/MI Children’s Work Group, DD/MI Steering Committee, EPSDT Steering Committee, Medicaid Advisory Committee (MAC), now incorporated into the Behavioral Health Planning Council (BHPC), the primary statewide advisory body for mental health and substance abuse issues, have been and continue to be actively involved in addressing the issues confronting the Collaborative. Groups that were formed as a function of the Collaborative, e.g., the Collaborative Steering Group, Oversight Group, Cross-Agency Teams, and as a function of the SE, e.g., the Local Collaboratives (LCs) and Regional Office teams, are actively engaged in all aspects of the new system and working hard to ensure its success.

The Collaborative has established clear and consistent processes for making policy and informing the public. Public meetings of the Collaborative are held every 4-5 weeks. A time for public input is provided at every meeting. In additions, the Collaborative has been meeting with stakeholders in public meetings that are widely circulated and well attended. Collaborative members have met with local collaborative leadership representatives multiple times. Documents coming out of those meetings have been provided to the Collaborative and in some cases, adopted as policy. Providers and consumers and family members, acting in the capacity of advisors, meet once a month with the staff of the Steering Committee and with VONM. Public meetings of the Behavioral Health Planning Council also occur monthly with subcommittee meetings including stakeholders held periodically throughout the year.
A. Statutory Authority

1. Waiver Authority. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

   a. ___ 1915(b)(1) – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.

   b. ___ 1915(b)(2) - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.

   c. X ___ 1915(b)(3) - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.

   d. X 1915(b)(4) - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

   The 1915(b)(4) waiver applies to the following programs
   ____ MCO
   X ___ PIHP
   ___ PAHP
       PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
   ____ FFS Selective Contracting program (please describe)

2. Sections Waived. Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):
a. **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

b. **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.

c. **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

d. **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If State seeks waivers of additional managed care provisions, please list here).

e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

**B. Delivery Systems**

1. **Delivery Systems**. The State will be using the following systems to deliver services:

   a. **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

   b. **PIHP**: Prepaid Inpatient Health Plan means an entity that:

      (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

      _X_ The PIHP is paid on a risk basis
The PIHP is paid on a non-risk basis

The NM Medicaid BH plan is a statewide capitated behavioral health carve-out program with the PIHP at full risk for BH services.

For those Medicaid beneficiaries who are not required to participate in the SE’s programs, Medicaid fee for service behavioral health services are available.

C  **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

The PAHP is paid on a risk basis

The PAHP is paid on a non-risk basis

**d. PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

**e. Fee-for-service (FFS) selective contracting:** A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:

- the same as stipulated in the state plan
- is different than stipulated in the state plan (please describe)

**f. Other:** (Please provide a brief narrative description of the model.)

**2. Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

- [X] **Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- **Open** cooperative procurement process (in which any qualifying contractor may participate)
- **Sole source** procurement
- **Other** (please describe)
A competitive process was used to select the Statewide Entity or SE with the experience and expertise required to provide the services described in the Medicaid Behavioral Health Benefit Package and to focus on reducing fragmentation and improving quality and access. The SE was required to ensure a smooth transition of customers from a variety of networks and funding mechanisms into a single behavioral health system within the first year of the contract.

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances

   The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

   The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries’ ability to access services.

The State requires that Medicaid BH beneficiaries enroll in one statewide PIHP to obtain BH services. Beneficiaries have a choice of the providers who offer the appropriate level of care within the SE’s provider network.

For those Medicaid beneficiaries who are not required to participate in the SE’s programs, Medicaid fee for service behavioral health services are available.

The SE provides all behavioral health services as required in the current New Mexico State Plan.

The SE maintains a statewide network of behavioral health providers in sufficient quantities so as to assure access to all customers. Medicaid beneficiaries may choose to access BH services through any contracted Medicaid provider who is able to deliver the appropriate level of care required. Certain Native American providers (IHS, tribal/pueblo and 638 providers) are deemed essential providers with which the SE must contract, so long as they meet requirements as Medicaid providers.

Because of the rural nature of much of the state of New Mexico, the SE has established and maintains a provider network that encompasses urban, rural and frontier areas in order to meet all program requirements. If network services are not available within the travel standards specified, the SE is required to reimburse other qualified and appropriate providers (non-network) to deliver the required service(s).
In order to meet access to care and timeliness standards, the Statewide Entity is required to contract with the majority of (appropriate) behavioral health care providers in the state of New Mexico. The SE is encouraged to provide more cost-effective services and to increase access to community-based services in less restrictive environments than were available prior to July, 2005.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

___ Two or more MCOs
___ Two or more primary care providers within one PCCM system.
___ A PCCM or one or more MCOs
___ Two or more PIHPs.
___ Two or more PAHPs.
X Other: (please describe)

New Mexico Medicaid beneficiaries may choose to access behavioral health services through any Medicaid contracted network provider who can deliver the appropriate level of care.

The State contracts with one PIHP (the SE). The State requires the SE to establish and maintain contracts with “essential” providers identified by Collaborative partners such as IHS, tribal, pueblo and 638 service providers; and assure network capacity to provide all required behavioral health services.

Under the provisions of the contract, in consultation with Collaborative agencies, including the Human Services Department (HSD), the SE will be required to have a Provider Network sufficient to meet access standards and offer choice to the extent practicable in New Mexico’s rural and frontier areas.

The SE will be required to:

- Provide for a sufficient network of behavioral health Medicaid providers as required to deliver the full range of behavioral health services according to the Medicaid BH benefit package.
- Build a statewide behavioral health Medicaid provider network that ensures access to all levels of behavioral health services, across a continuum from the most to the least restrictive setting;
- Build a statewide behavioral health Medicaid provider network that will ensure meeting access to care and timeliness standards, as follows:
  - Access to care standards:
    - Ninety per cent of current members in urban locations will have access to an appropriate (defined as licensed, credentialed, in active practice and willing and able to accept new behavioral health customers) behavioral health provider within a driving distance of thirty (30) miles;
90% of current members in rural locations will have access to an appropriate behavioral health provider within a driving distance of sixty (60) miles; and

90% of current members in frontier locations will have access to an appropriate behavioral health provider within a driving distance of ninety (90) miles.

- Standards for appointment timeliness:
  - Ninety-five per cent (95%) of all customers requesting urgent behavioral health appointments will be seen within twenty-four (24) hours of placing the request; and
  - Ninety-five per cent (95%) of all customers requesting routine (non-urgent) behavioral health appointments will be seen within ten (10) days of placing the request.

3. **Rural Exception.**

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. **1915(b)(4) Selective Contracting**

- Beneficiaries will be limited to a single provider in their service area (please define service area).
- Beneficiaries will be given a choice of providers in their service area.

D. **Geographic Areas Served by the Waiver**

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

   - **X** Statewide -- all counties, zip codes, or regions of the State
   - Less than Statewide

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract
<table>
<thead>
<tr>
<th>City/County/Region</th>
<th>Type of Program (PCCM, MCO, PIHP, or PAHP)</th>
<th>Name of Entity (for MCO, PIHP, PAHP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health: New Mexico Statewide</td>
<td>SFY08: PIHP</td>
<td>ValueOptions of New Mexico</td>
</tr>
<tr>
<td>COUNTIES: Urban:</td>
<td>SFY08: PIHP</td>
<td>ValueOptions of New Mexico</td>
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<td>• Bernalillo</td>
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<td>Rural:</td>
<td>SFY08: PIHP</td>
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<td>• Los Alamos</td>
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<td>• Curry</td>
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<tr>
<td>City/County/Region</td>
<td>Type of Program (PCCM, MCO, PIHP, or PAHP)</td>
<td>Name of Entity (for MCO, PIHP, PAHP)</td>
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<td><strong>Frontier:</strong></td>
<td>SFY08:PIHP</td>
<td>ValueOptions of New Mexico</td>
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<td>• Catron</td>
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<td>• Harding</td>
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<td>• Cibola</td>
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<td>• Rio Arriba</td>
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</table>
E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State’s specific circumstances.

1. **Included Populations**. The following populations are included in the Waiver Program:

   - **Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
     - X Mandatory enrollment
     - ___ Voluntary enrollment

   - **Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
     - ___ Mandatory enrollment
     - ___ Voluntary enrollment

   - **Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
     - X Mandatory enrollment
     - ___ Voluntary enrollment

   - **Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
     - X Mandatory enrollment
     - ___ Voluntary enrollment

   - **Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
     - X Mandatory enrollment
     - ___ Voluntary enrollment
**Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- **Mandatory enrollment**
- **Voluntary enrollment**

**TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.

- **Mandatory enrollment**
- **Voluntary enrollment**

**Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

Please note that all excluded populations will continue to receive BH services under New Mexico Medicaid’s fee for service (FFS) program.

- **Medicare Dual Eligible**—Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))
- **Poverty Level Pregnant Women**—Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

- **Other Insurance**—Medicaid beneficiaries who have other health insurance.

- **Reside in Nursing Facility or ICF/MR**—Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

- **Enrolled in Another Managed Care Program**—Medicaid beneficiaries who are enrolled in another Medicaid managed care program.
___ Elgibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

___ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

___ American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

OPT in

___ Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

___ SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

___ Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

___ Other (Please define):

- Clients participating in the Health Insurance Premium Payment Program (HIPP);
- Children in out-of-state foster care or adoption placements through CYFD;
- Breast and cervical cancer medical program;
- Clients eligible for family planning services only; and
- State Coverage Initiative (SCI) ages 19-64, eligible for category 062.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

All physical health services are addressed in a companion 1915B waiver. The table of behavioral health services are listed below:

<table>
<thead>
<tr>
<th>Definition of Service</th>
<th>State Plan Approved</th>
<th>1915(b)4 Waiver Services</th>
<th>PIHP Cap’d Reimb.</th>
<th>FFS Reimb.[5]</th>
<th>FFS Reimb. impacted by PIHP/PAHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Type</td>
<td>BH</td>
<td>[3]</td>
<td>[4]</td>
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<tr>
<td>Behavior Management Skills Development Services (&lt;21) BH*</td>
<td>XXX</td>
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<tr>
<td>Case Management</td>
<td>XXX</td>
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<td>BH:</td>
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<tr>
<td>- for the medically at-risk &lt;21</td>
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<tr>
<td>- for the chronically mentally ill 18 and older</td>
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<tr>
<td>Comprehensive Community Support Services: BH</td>
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<td>EPSDT</td>
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<td>BH:</td>
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<td>- BH Services</td>
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<td>Family Planning Services</td>
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<td>BH (pre-decision counseling only by qualified and licensed counselors)</td>
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<td>XXX</td>
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<tr>
<td>Federally Qualified Health Center Services</td>
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<tr>
<td>Non-accredited Residential treatment Center and Group Home Services (&lt;21):</td>
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<td>BH</td>
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<td>Indian Health Services (IHS):</td>
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<td>BH</td>
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<tr>
<td>Inpatient Hospital Psychiatric Services (in freestanding psych hospital or general hospital)</td>
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<td>BH:</td>
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<td>BH:</td>
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<td>- Inpatient</td>
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<td>- Outpatient</td>
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<td>Multi-Systemic Therapy BH</td>
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<td>Non-Emergency Transportation</td>
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<td>BH (offered through the three MCO’s)</td>
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<td>Other Fee-For-Service Services</td>
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<td>Outpatient Hospital BH:</td>
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<td>- Day Treatment (&lt;21)</td>
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<tr>
<td>- Partial Psychiatric Hospitalization</td>
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<td>- Ambulatory Detox</td>
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<td>Outpatient: Non Hospital – BH:</td>
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<td>Individual, Group &amp; Family Psychotherapy</td>
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<td>Day Treatment Service &lt;21</td>
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<td>Testing Services</td>
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<td>Pharmacy BH</td>
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<td>Physician BH:</td>
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<td>- Psychiatrists</td>
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<td>- Physician BH Services</td>
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<td>Professional Office &amp; Clinic BH</td>
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<td>Psychiatric Medical Institution for Children BH:</td>
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### Legend

1. **Definition of Service:** this list includes
   - ALL benefit behavioral health services available in NM’s State Medicaid Plan, regardless of whether or not they will be included in or excluded from the Waiver; and
   - Subsets of state plan amendment services which will be carved out;

2. **State Plan Approved:** This column includes all Medicaid State Plan approved services. Only Medicaid State Plan approved services can be included in cost effectiveness. It will also serve to distinguish existing from plan benefit services.

3. **1915(b) 4 Waiver Services:** This column includes only those services which are NOT currently Medicaid State Plan Approved services, distinguishing new services available under the Waiver versus existing Medicaid services.

4. **PIHP/PAHP Capitated Reimbursement:** This column will include all services to be included in the capitation or other reimbursement to the PIHP. All services checked in this column should be marked in Appendix __, in the “Capitated Reimbursement” column.

5. **FFS Capitated Reimbursement:** this column includes ONLY those services that will NOT be the responsibility of the PIHP, i.e., not include in the reimbursement paid to the SE. This column DOES NOT include services impacted by the SE (PIHP).

6. **FFS Reimbursement Impacted by PIHP:** This column should be checked for all services that are not the responsibility of the SE (PIHP) but are impacted by it. For example, if the PIHP is responsible for psychiatric services but the State (or the MCOs) pays for pharmacy on a FFS basis, the PIHP/PAHP (SE) will impact pharmacy use because access to some psychotropic medications requires a psychiatrist’s/MD’s prescription. All services checked in this column should appear in Appendix __ (in the Fee for Service Reimbursement” column. Services NOT impacted by the SE should NOT be included.

1. **Assurances,**
The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. **Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.
3. **Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.
- The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.
- The State will pay for all family planning services, whether provided by network or out-of-network providers.

Other (please explain):

_X_ Family planning services are not included under the waiver.

4. **FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- The program is voluntary, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.

_X_ The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

- The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

HSD/MAD guarantees enrollees access to FQHC services by requiring the statewide entity to contract with FQHC facilities. This requirement is reflected in both managed care policy and is stated in the individual contract with the statewide entity.

5. **EPSDT Requirements.**
The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. **1915(b)(3) Services.**

This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. **Self-referrals.**

The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

- Enrollees may self-refer to all behavioral health services.
Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries’ access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The current access to care standards are as follows:

- Ninety per cent of current members in urban locations will have access to an appropriate (defined as licensed, credentialed, in active practice and willing and able to accept new behavioral health customers) behavioral health provider within a driving distance of thirty (30) miles;
- Ninety per cent of current members in rural locations will have access to an appropriate behavioral health provider within a driving distance of sixty (60) miles; and
- Ninety per cent of current members in frontier locations will have access to appropriate behavioral health providers within a driving distance of ninety (90) miles.

The current standards for appointment timeliness are as follows:

- Ninety-nine per cent (99%) of all customers requesting urgent behavioral health appointments will be seen within twenty-four (24) hours of placing the request; and
- Ninety-nine per cent (99%) of all customers requesting routine (non-urgent) behavioral health appointments will be seen within fourteen (14) days of placing the request, unless the member agrees to a later date.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional
Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

*If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.*

2. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

   a. **Availability Standards.** The State’s PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary’s normal means of transportation, for waiver enrollees’ access to the following providers. For each provider type checked, please describe the standard.

   1. ___ PCPs (please describe):
   2. ___ Specialists (please describe):
   3. ___ Ancillary providers (please describe):
   4. ___ Dental (please describe):
   5. ___ Hospitals (please describe):
   6. ___ Mental Health (please describe):
   7. ___ Pharmacies (please describe):
   8. ___ Substance Abuse Treatment Providers (please describe):
   9. ___ Other providers (please describe):

   b. **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State’s PCCM Program includes established standards for appointment scheduling for waiver enrollee’s access to the following providers.

   1. ___ PCPs (please describe):
   2. ___ Specialists (please describe):
   3. ___ Ancillary providers (please describe):
   4. ___ Dental (please describe):
5. ___ Mental Health (please describe):

6. ___ Substance Abuse Treatment Providers (please describe):

7. ___ Urgent care (please describe):

8. ___ Other providers (please describe):

c. ___ In-Office Waiting Times: The State’s PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ___ PCPs (please describe):

2. ___ Specialists (please describe):

3. ___ Ancillary providers (please describe):

4. ___ Dental (please describe):

5. ___ Mental Health (please describe):

6. ___ Substance Abuse Treatment Providers (please describe):

7. ___ Other providers (please describe):

d. ___ Other Access Standards (please describe)

3. Details for 1915(b)(4) FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

   X   The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

   ___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. The State has set enrollment limits for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.

b. The State ensures that there are adequate numbers of PCCM PCPs with open panels. Please describe the State’s standard.

c. The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State’s standard for adequate PCP capacity.

d. The State compares numbers of providers before and during the Waiver. Please modify the chart below to reflect your State’s PCCM program and complete the following.

<table>
<thead>
<tr>
<th>Providers</th>
<th># Before Waiver</th>
<th># In Current Waiver</th>
<th># Expected in Renewal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatricians</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Family Practitioners</td>
<td></td>
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<tr>
<td>Internists</td>
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<td></td>
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<tr>
<td>General Practitioners</td>
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<td></td>
<td></td>
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<tr>
<td>OB/GYN and GYN</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FQHCs</td>
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<td></td>
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<tr>
<td>RHCs</td>
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<td></td>
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<tr>
<td>Nurse Practitioners</td>
<td></td>
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<td></td>
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<tr>
<td>Providers</td>
<td># Before Waiver</td>
<td># In Current Waiver</td>
<td># Expected in Renewal</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Nurse Midwives</td>
<td></td>
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<tr>
<td>Indian Health Service Clinics</td>
<td></td>
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<tr>
<td>Additional Types of Provider to be in PCCM</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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</tbody>
</table>

*Please note any limitations to the data in the chart above here:

  e. ___ The State ensures adequate geographic distribution of PCCMs. Please describe the State’s standard.

  f. ___ **PCP: Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

<table>
<thead>
<tr>
<th>Area(City/County/Region)</th>
<th>PCCM-to-Enrollee Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td><strong>Statewide Average:</strong> (e.g. 1:500 and 1:1,000)</td>
<td></td>
</tr>
</tbody>
</table>

  g. ___ **Other capacity standards** (please describe):

3. **Details for 1915(b)(4) FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) –
for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

   X The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

   By facilitating timely access to and utilization of appropriate BH services, care coordination can help to avoid duplication of services and reduce the costs of unnecessary services, and reduce the incidence and costs of inappropriate emergency room and inpatient care. Care coordination is a function that is performed across all populations who need this assistance. Care coordination assists customers and their families with special behavioral health care needs on an as needed basis. It is customer-centered and customer-directed, family-focused when appropriate, culturally competent, strength-based and recovery/resiliency oriented. Care coordination ensures that medical and behavioral health needs are identified and services are provided and coordinated with the customer, and family if appropriate.

   Care coordination of children’s BH services involves children and their families throughout the decision-making process from initial planning through implementation and evaluation. Care coordination of adult BH services involves the adult receiving services and is directed by that adult with assistance in decision-making as needed. Care coordination decisions are based on clinical criteria for determining medically necessary covered BH services in order to increase outcomes for customers, not on other financial or administrative considerations.

   Care coordination is an administrative function rather than a service and is not separately reimbursed by behavioral health fund sources. It is not the same as case management which is a therapeutic service provided for only those customers/families in need of such services and in different levels of intensity depending on the customer/family’s need. Under the provisions of the contract, Care coordination will continue to be operated by the SE as a dedicated independent function that is linked to other SE systems such as quality improvement/management, customer services, and complaints and grievances. The care coordinator coordinates services within the behavioral health delivery system, as well as with other service providing systems.

   The SE, in conjunction with the Collaborative, has established criteria for identifying persons with high needs, high risk and high utilization or multi-system or multi-provider services to initiate treatment planning and service coordination with the customer and others, including individual family service plan (IFSP) and individual service plan (ISP)
teams, who are working with the customer. Criteria includes such issues as: acuity of need, need for multiple services and/or systems, past high usage of behavioral health services, children transitioning from the children’s system to the adult system; and high risk of needing intensive behavioral health services.

The SE must work with the identified customer and/or family to identify a BH (or physical health, as appropriate) provider. The SE uses a process for implementation of a single, developmentally appropriate screening/assessment process and customer/family-driven plan of care to assure consistent care across providers and involved systems. The SE BH care coordination function is responsible for sharing the service plan with primary care providers to ensure optimum care and communication between primary care and behavioral health care as well as among involved behavioral health providers and across other service providing systems involved in the customer’s life.

Physical and behavioral health services must be well coordinated. Both physical and behavioral health care providers have access to relevant medical records of mutually served individuals to ensure maximum benefits of services for that person. Confidentiality and HIPAA laws apply during this coordination process.

The SE must have policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of individuals served. Similar mechanisms for coordination with behavioral health providers are required of physical health providers in the Medicaid program. The Medical Director of the SE is required to meet regularly with Medical Directors of the Medicaid managed care organizations (MCOs) that provide physical health care for the Medicaid program, the Medical Directors of relevant programs of the Collaborative agencies (especially the Human Services Department, the Department of Health, Children, Youth and Families Department and the New Mexico Corrections Department), and the Medical or Clinical Director of any vendor that implements utilization review processes for the Medicaid fee-for-service program to assure coordination between physical and behavioral health care occurs for individual service recipients and between systems of care. Key medical directors or clinical leaders of critical health and behavioral health providers also work with the SE, the Collaborative, and MCO Medical Directors to maximize mechanisms for coordination of care. The Medical Directors group may engage others and work closely with the primary care network, including but not limited to federally qualified health centers (FQHCs) and rural health clinics to maximize coordination between physical and behavioral health care. Placement of behavioral health practitioners in these primary care clinics may be one approach utilized to increase care coordination between systems of care. Processes, forms, approaches and requirements that are implemented as a result of these meetings and other efforts of the Collaborative, must be adopted and adhered to by the SE.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is
requested, the managed care program(s) to which the waiver will apply, and what
the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP
contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and
42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the
State assures that contracts that comply with these provisions will be submitted to the
CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO,
PIHP, PAHP, or PCCM.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. ___ The plan is a PIHP/PAHP, and the State has determined that based on the plan’s
scope of services, and how the State has organized the delivery system, that the
PIHP/PAHP need not meet the requirements for additional services for
enrollees with special health care needs in 42 CFR 438.208. Please provide
justification for this determination.

b. ___ Identification. The State has a mechanism to identify persons with special
health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by
the State. Please describe.

Individuals with special health care needs (ISHCN) are defined as individuals
who have or are at an increased risk for a chronic mental, developmental,
behavioral, neurobiological or emotional condition(s) and who also require health
and related services of a type or amount beyond that required by other individuals.
ISHCN have ongoing health conditions, high or complex service utilization and
low to severe functional limitations. The guiding principle for this definition is
that the person must be at individual risk and have a functional need. The primary
purpose of the definition is to identify ISHCN so that the statewide entity can
facilitate access to appropriate services. The definition also allows for a flexible
targeting of individuals based on clinical justification and for discharging them
when special services are no longer needed.

c. ___ Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using
appropriate health care professionals, to assess each enrollee identified by the
State to identify any ongoing special conditions that require a course of treatment
or regular care monitoring. Please describe.

The SE must have established policies and procedures to provide appropriate
levels of BH clinical care and care coordination for ISHCN. The SE has an
internal operational process, in accordance with policy and procedure, to target
Medicaid members for purposes of applying stratification criteria to identify those
who are potential ISHCN. The contractor has provided HSD with the applicable policy and procedure describing the targeting and stratification process.

The SE must have written policies and procedures to ensure that each member identified as having special health care needs is assessed by an appropriate health care professional. The SE must have written policies and procedures for educating ISHCN and, as appropriate, parent(s) or legal guardians, that care coordination is available and when it may be appropriate to their needs.

d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. **X** Developed by enrollees’ primary care provider with enrollee participation, and in consultation with any specialists’ care for the enrollee

2. ____ Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)

3. **X** In accord with any applicable State quality assurance and utilization review standards.

e. **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee’s condition and identified needs.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

   a. ____ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee’s needs.

   b. ____ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee’s overall health care.

   c. ____ Each enrollee is receives **health education/promotion** information. Please explain.

   d. ____ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
e. ___ There is appropriate and confidential exchange of information among providers.

f. ___ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.

g. ___ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.

h. ___ Additional case management is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager’s files).

i. ___ Referrals: Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers’ files.

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.
Section A: Program Description

Part III: Quality

1. **Assurances for MCO or PIHP programs.**

   **X** The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

   ____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

   **X** The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

   **X** Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.

   **X** The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):
<table>
<thead>
<tr>
<th>Program</th>
<th>Name of Organization</th>
<th>Activities Conducted</th>
<th>Mandatory Activities</th>
<th>Optional Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO/PIHP</td>
<td>SCHIP Design study</td>
<td>1) Validation of performance measurement projects;</td>
<td>1) Encounter data validation study;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrollee satisfaction studies</td>
<td>2) Validation of SE performance measures;</td>
<td>2) Consumer and provider surveys; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical focus studies</td>
<td>3) Annual Review to determine SE compliance with contract and national quality and standards.</td>
<td>3) Ad hoc reviews of performance measurement activity.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4) Independent Assessment performed on the Medicaid agency twice in the course of the CMS waiver.</td>
<td>4) Quarterly audits of BH Utilization Review denials, as well as other Ad Hoc Audits based on reports/data.</td>
<td></td>
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<tr>
<td>NMMRA</td>
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</table>

The New Mexico Medicaid Behavioral Health (BH) Quality Strategy contains multiple elements. Quality Management requires an integrated approach linking knowledge, structure and processes together throughout New Mexico Medicaid, in order to accurately assess and improve quality. The goal of quality improvement activities is to increase the quality of clinical monitoring and oversight of the Contractor’s (whether MCO or SE) BH service delivery system.

2. **Assurances For PAHP program.**

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

___ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR
If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

   a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

   b. ___ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

      1. ___ Provide education and informal mailings to beneficiaries and PCCMs;
      2. ___ Initiate telephone and/or mail inquiries and follow-up;
      3. ___ Request PCCM’s response to identified problems;
      4. ___ Refer to program staff for further investigation;
      5. ___ Send warning letters to PCCMs;
      6. ___ Refer to State’s medical staff for investigation;
      7. ___ Institute corrective action plans and follow-up;
      8. ___ Change an enrollee’s PCCM;
      9. ___ Institute a restriction on the types of enrollees;
     10. ___ Further limit the number of assignments;
     11. ___ Ban new assignments;
     12. ___ Transfer some or all assignments to different PCCMs;
     13. ___ Suspend or terminate PCCM agreement;
     14. ___ Suspend or terminate as Medicaid providers; and
     15. ___ Other (explain):
Selection and Retention of Providers: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).

2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
   A. ___ Initial credentialing
   B. ___ Performance measures, including those obtained through the following (check all that apply):
      ___ The utilization management system.
      ___ The complaint and appeals system.
      ___ Enrollee surveys.
      ___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

5. ___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

6. ___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

7. ___ Other (please describe).
d. ____ Other quality standards (please describe):

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:
Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1. ____ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

All marketing materials must be accurate, culturally competent and written in a manner that is understandable by the customers/families to be served. HSD will approve all marketing and educational materials. In accordance with current HSD/MAD (Human Services Department, Medical Assistance Division) Policy,
marketing materials for Medicaid beneficiaries may consist of brochures, leaflets, newspaper, magazine, radio, television, billboard, yellow page advertisement, website and presentation materials.

3. X The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

In accordance with current HSD/MAD policy, the Statewide Entity may send solicited and unsolicited mailings to Medicaid beneficiaries, with HSD’s approval. Unsolicited mailings are defined as newsletters; notification of outreach events and customer services meetings; and educational materials and literature related to preventive medicine initiatives (such as drug and alcohol awareness).

HSD/MAD will approve the content of mailings for Medicaid beneficiaries except health education materials. The target audience of the mailings will be prior approved by HSD/MAD.

b. Description. Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. X The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

All marketing materials must be accurate, culturally competent and written in a manner that is understandable by the customers/families to be served. HSD will approve all marketing and educational materials.

Currently, HSD/MAD reviews all marketing and informational materials that are distributed through the statewide entity. The SE must submit materials to HSD/MAD before distribution to Medicaid members.

2. ___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

The State has chosen these languages because (check any that apply):
Consistent with HSD/MAD regulations, Medicaid marketing and outreach materials must meet requirements for all communication with Medicaid members as delineated in the Customer Bill of Rights.

The SE will make marketing materials available in Spanish and Native languages (when/where possible). Materials should be available in culturally and linguistically appropriate formats and at no higher than a sixth (6th) grade reading level.

B. Information to Potential Enrollees and Enrollees

1. Assurances.

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. Non-English Languages
Potential enrollee and enrollee materials will be translated into the prevalent non-English languages listed below (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as: (check any that apply):

1. __ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines “significant.”
2. __ The languages spoken by approximately five (5) percent or more of the potential enrollee/ enrollee population.
3. __ Other (please explain):

Consistent with HSD/MAD regulations, Medicaid marketing and outreach materials must meet requirements for all communication with Medicaid members as delineated in the Customer Bill of Rights. As stated in the Customer Bill of Rights, the Contractor’s communication with customers will be responsive to the various populations by demonstrating cultural competence in the materials and services provided to customers.

The SE will make materials available in Spanish and Native languages (when/where possible). Materials should be available in culturally and linguistically appropriate formats and at no higher than a sixth (6th) grade reading level.

Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

The SE is required to provide translation services for Medicaid customers, in English, Spanish and Native languages, and in linguistically and culturally appropriate formats for persons who are blind, deaf, hard of hearing or visually impaired, as needed.

The State will have a mechanism in place to help enrollees and potential enrollees understand the behavioral health program. Please describe.

The Statewide Entity, with the assistance of the State of New Mexico, HSD and Medicaid, will be required to provide the following program education and assistance:

- Schedule region-specific education and assistance to customers and providers regarding the State’s publicly funded behavioral health system;
- Develop an educational/training curriculum in collaboration with individuals and families and approved by the State at least ninety days prior to implementation of the new behavioral health care system;
- Provide ongoing training and education regarding a benefit package of services, including: behavioral health information; provider education; and billing codes, processes and procedures;
• Disseminate the principles and core values of the new behavioral health system, particularly the concepts of recovery, resiliency and empowerment;
• Provide clearly written, culturally and linguistically appropriate, informational materials designed and distributed with customers and families in mind;
• Implement a toll-free, 24-hour bilingual telephone bank staffed by customer friendly staff to assist customers and providers with identifying and locating appropriate services and/or answering questions; and
• Disseminate policies and procedures to customers and providers regarding the complaint, grievance and appeals processes that are compliant with federal and state laws, regulations and guidelines.
• Disseminate materials in not more than sixth grade reading level, and make them available for those who are blind, deaf, hard of hearing or visually impaired.

The SE will be required to maintain all of the above-listed systems. In addition, the Statewide Entity will be responsible for providing education, training and technical assistance to customers, providers and key stakeholders. The Statewide Entity and providers will assist individuals and families with identifying the spectrum of available services, payer source(s) and eligibility requirements including ways those customers and their families may access information and services. The Statewide Entity and providers will disseminate clear policies regarding an individual’s right for self-determination.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

___ State
___ contractor (please specify)
___ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

Populations included under this waiver for managed care behavioral health services will automatically be enrolled with the SE.

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

(i) ___ the State
(ii) X ___ State contractor (please specify):

The statewide entity (SE) will be responsible for providing required information to existing enrollees.

(iii) ___ the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider
C. Enrollment and Disenrollment

1. Assurances.

[X] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

[X] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details. Please describe the State’s enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. [X] Outreach. The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

For Medicaid beneficiaries, HSD/MAD Client Services Bureau (CSB) will coordinate and/or participate in statewide community events to promote Medicaid consumer outreach and education regarding managed care, behavioral health care and children’s health care insurance coverage. MAD/CSB will collaborate closely at these events with community partners to disseminate information and serve as a resource. The SE will be expected to continue and further community outreach and education activities.

The SE will maintain responsibility for outreach activities by providing education, training and technical assistance to customers, providers and key stakeholders. The SE and providers will assist individuals and families with identifying the spectrum of available services, payer source(s) and eligibility requirements including ways those customers and their families may access information and services. The SE and providers
will be expected to disseminate clear policies regarding the individual’s right for self-determination and choice of services and service settings, unless a court of law determines that the individual must be served in a particular treatment facility or receive particular identified treatment services.

b. Administration of Enrollment Process.

**X** State staff conducts the enrollment process.

___ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

___ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: __________________

Please list the functions that the contractor will perform:

___ choice counseling

___ enrollment

___ other (please describe):

___ State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

___ This is a new program. Please describe the implementation schedule (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

___ This is an existing program that will be expanded during the renewal period. Please describe the implementation schedule (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

___ If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

i. ___ Potential enrollees will have ____ days/month(s) to choose a plan.

ii. ___ Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.
The State **automatically enrolls** beneficiaries

- on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
- on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
- on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: ____________

The State provides **guaranteed eligibility** of 1-6 months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

- The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

- The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

### d. Disenrollment:

- The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.
  - i. Enrollee submits request to State.
  - ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
  - iii. Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

- The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

- The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of ________ months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).
Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee’s health care needs):

___ The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

i. ___ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

ii. ___ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ___ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM’s caseload.

___ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. **Enrollee rights**

1. **Assurances.**

   ___ The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

   _____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

   ___ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. **Assurances for All Programs.** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:
   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

The State assures CMS that it will comply with Federal Regulations found at 42 CFR 431 Subpart E.

2. **Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
3. **Details for MCO or PIHP programs.**

a. **Direct access to fair hearing.**
   - ___ The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State fair hearing.
   - **X** The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a State fair hearing.

d. **Timeframes**
   - **X** The State’s timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is **ninety (90)** days (between 20 and 90).
   - **X** The State’s timeframe within which an enrollee must file a **grievance** is **ninety (90)** days.

c. **Special Needs**
   - **X** The State has special processes in place for persons with special needs. Please describe.

The SE will have available reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter service, translation services and toll-free numbers that have adequate TTY/TTY and interpreter capability.

4. **Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee’s freedom to make a request for a fair hearing or a PCCM or PAHP enrollee’s direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

   ___ The State has a grievance procedure for its ___ PCCM and/or ___ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

   ___ The grievance procedures is operated by:
   - ___ the State
   - ___ the State’s contractor. Please identify: ___________
   - ___ the PCCM
   - ___ the PAHP.

   ___ Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)
Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

Specifies a time frame from the date of action for the enrollee to file a request for review, which is: ______ (please specify for each type of request for review)

Has time frames for resolving requests for review. Specify the time period set: ______ (please specify for each type of request for review)

Establishes and maintains an expedited review process for the following reasons:______. Specify the time frame set by the State for this process____

Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

Other (please explain):

F. Program Integrity

1. Assurances.

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

(1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or

(2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

(1) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;

(2) A person with beneficial ownership of five percent or more of the MCO’s, PCCM’s, PIHP’s, or PAHP’s equity;

(3) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO’s, PCCM’s, PIHP’s, or PAHP’s obligations under its contract with the State.
The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3) Employs or contracts directly or indirectly with an individual or entity that is
   a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

Assurances For MCO or PIHP programs

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

<table>
<thead>
<tr>
<th>Program Impact</th>
<th>(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)</td>
</tr>
<tr>
<td>Quality</td>
<td>(Coverage and Authorization, Provider Selection, Quality of Care)</td>
</tr>
</tbody>
</table>

For each of the programs authorized under this waiver, this Part identifies how the State will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under
“Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.

- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”

- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.
<table>
<thead>
<tr>
<th>Monitoring Activity</th>
<th>Evaluation of Program Impact</th>
<th>Evaluation of Access</th>
<th>Evaluation of Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Choice</td>
<td>Marketing</td>
<td>Enroll/Disenroll</td>
</tr>
<tr>
<td>Accreditation for Non-duplication*</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>*New Mexico Medicaid will recognize either accreditation or the meeting of national standards.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation for Participation*</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>* New Mexico Medicaid will recognize either accreditation or the meeting of national standards.</td>
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<tr>
<td>Consumer Self-Report data</td>
<td>X</td>
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<tr>
<td>Data Analysis (non-claims)</td>
<td>X</td>
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<tr>
<td>Enrollee Hotlines</td>
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<tr>
<td>Focused Studies</td>
<td>X</td>
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<tr>
<td>Geographic mapping</td>
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<tr>
<td>Independent Assessment</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Measure any Disparities by Racial or Ethnic Groups</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Monitoring Activity</td>
<td>Evaluation of Program Impact</td>
<td>Evaluation of Access</td>
<td>Evaluation of Quality</td>
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<tr>
<td></td>
<td>Choice</td>
<td>Marketing</td>
<td>Enroll/Disenroll</td>
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<tr>
<td>Network Adequacy Assurance by Plan</td>
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<td>X</td>
<td>X</td>
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<td>BH Ombudsman</td>
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<td>X</td>
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<tr>
<td>On-Site Review</td>
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<tr>
<td>Performance Improvement Projects* [*Subsumed by Performance Measures]</td>
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<tr>
<td>Performance Measures</td>
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<tr>
<td>Periodic Comparison of # of Providers</td>
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<td>Profile Utilization by Provider Caseload</td>
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<tr>
<td>Provider Self-Report Data</td>
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<tr>
<td>Test 24/7 PCP Availability</td>
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<tr>
<td>Utilization Review</td>
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<tr>
<td>Other: (describe) MHSIP</td>
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<tr>
<td>Monitoring Activity</td>
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<td>Choice</td>
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<td>Enroll/Disenroll</td>
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<td>Report Data</td>
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<td>Test 24/7 PCP Availability</td>
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<tr>
<td>Utilization Review</td>
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<tr>
<td>Other (describe):</td>
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</tr>
<tr>
<td>State review of materials prior to public release</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:
- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. __ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization’s standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)
   — NCQA
   — JCAHO
   — AAAHC
   — Other (please describe)

b. ___ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)
   — NCQA
   — JCAHO
   — AAAHC
   — Other (please describe)

c. ___ X Consumer Self-Report data
   — CAHPS (please identify which one(s))
   — State-developed survey
   — Disenrollment survey
   — Consumer/beneficiary focus groups
   — MHSIP Data

A consumer survey will be required of the SE; in the past, it has been the MHSIP. In the new program, a survey will be utilized that meets the needs of the SE, the Collaborative and Medicaid.

HSD will require that the SE continue to utilize the Mental Health Statistical Improvement Project protocol, which historically has consisted of an annual MHSIP report from each Managed Care Organization (MCO)
since 1999. The SE will be required to utilize customer surveys as part of the MHSIP process.

**X** State complaint and grievance system

The SE has established policies and procedures for complaints, grievances and appeals so that customer and family concerns are addressed promptly. Federal Medicaid and Balanced Budget Act requirements must be followed for Medicaid eligible customers, including the right to a fair hearing for any services denied. The SE is required to submit reports regarding customer and provider complaints and grievances.

There is a tracking system to look for trends in number and type of complaints/grievances filed, and to oversee the integrity of the routing process that assure all complaints or grievances received anywhere in the system are appropriately routed.

d. **X** Data Analysis (non-claims)

**X** Denials of referral requests

Medicaid provides oversight and has developed reporting mechanisms that include staff participation and assurance of the appropriate tracking of items related to various funding sources, including Medicaid.

Data will be collected for use as a baseline for tracking the SE’s performance on these measures. There will be oversight and monitoring of protocols and procedures developed and implemented for all of the SE’s utilization management and review processes.

Based on both past history and current/projected needs, a monitoring system was developed by the SE to monitor the services provided through the SE and identify potential systems issues.

The State defines BH denials as follows:

1) **Denial-Administrative**: Administrative denials of authorization requests due to provider noncompliance with administrative policies and procedures established by either the Salud! MCO or Medical Assistance Division.

2) **Denial-Clinical**: Clinical denials are nonauthorization decisions at the time of an initial request for a Medicaid service based on the client not meeting medical necessity for the requested service. The UM staff may recommend an alternative service, based on the client’s need for a lower level of service. If the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.
3) **Reduction of Care**: A reduction of care occurs when the UM staff authorizes the type of service requested by the provider but in lesser amounts or units of service, based on the client’s medical need, than was originally requested.

4) **Termination of Care**: Terminations of care address those utilization management reviews (concurrent) that demonstrate that the client no longer meets medical necessity for the current level of care and a termination of care is assigned by the UM entity.

The current data is being collected for use as a baseline for tracking the SE’s performance on these measures. There will be Collaborative staff monitoring and oversight protocols and procedures developed and implemented for all of the SE’s utilization management and review processes.

- **X** Disenrollment requests by enrollee
  - ___ From plan
  - ___ From PCP within plan

A beneficiary may request to disenroll from Medicaid managed care programs to Medicaid fee for service programs administered by the SE by submitting a written request to HSD and the State. HSD and the state will review the request and furnish a written response to the beneficiary and the SE in a timely manner.

- **X** Grievances and appeals data
  - ___ PCP termination rates and reasons

HSD will assure that the SE has a complaint and grievance process that can be accessed by any customer or provider. In addition, each State agency within the Collaborative will have a process that assures that any complaint or grievance it receives will be appropriately routed.

Complaints or grievances involving Medicaid will follow all state and federal regulations, including the BBA.

The SE must provide a quarterly report to the Collaborative of all grievances received, segregated by fund sources and populations, including Medicaid.

- ___ Other (please describe)

e. **X** Enrollee Hotlines operated by State

The data received from the BH- and the New Mexikids Hotlines will continue to be collected and monitored and current data will be used as a baseline for oversight of the SE’s performance. In addition, the State of New Mexico is in the process of developing and implementing a 24-hour Nurse Hotline.

f. **X** Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions).
Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

HSD may request focused studies/audits on clinical or non-clinical indicators in order to evaluate/assess the SE’s performance in meeting requirements for providing appropriate services to Medicaid customers.

g. **X** Geographic mapping of provider network

The SE will be required to submit quarterly reports detailing their provider networks. For Medicaid beneficiaries, the data will be tracked and trended for any evidence of decreased access to or availability of BH services/providers.

h. **X** Independent Assessment of program impact, access, quality, and cost-effectiveness (Required for first two waiver periods)

The EQRO contract will be managed within Medicaid. Medicaid contracts with an EQRO (External Quality Review Organization) to perform the required Independent Assessment (IA) of the Human Services Department’s management and monitoring of the managed care contracts. The framework for the assessment is based on guidelines established by the Centers for Medicare and Medicaid Services (CMS). An IA will be performed on a scheduled basis during the course of the single Statewide Entity’s BH contract.

i. Measurement of any disparities by racial or ethnic groups

j. **X** Network adequacy assurance submitted by plan [Required for MCO/PIHP/PAHP]

The SE will be required to submit quarterly behavioral health geo-access reports detailing each of the services provided in the Medicaid behavioral health benefit package.

k. **X** BH Ombudsman

The position of the New Mexico Medicaid BH Ombudsman was developed in the winter of 2001 and will continue to be actively utilized in the new SE system, in conjunction with ombudspersons associated with the other Collaborative agencies.

l. **X** On-site review

The SE will be audited via an onsite review at least annually by the EQRO, in order to monitor and oversee the consistent application of appropriate clinical criteria, including the Medicaid definition for medically necessary services. If deficiencies are found, a corrective action plan (CAP) will be required, monitored by the State with a follow up review/audit to evaluate the efficacy of the CAP.

m. **X** Performance Improvement projects [Required for MCO/PIHP]
The SE is required to have internal Performance Improvements projects that are identified within the organization as opportunities for improvement. Two projects were selected and initiated in the course of this waiver. The PIP program was audited by the EQRO in the spring of 2006.

n. **X** Performance measures [Required for MCO/PIHP]

Performance measures that the State used for evaluation and monitoring activities with the SE were focused on assuring a smooth transition, continuing current service delivery and service capacity, meeting state and federal data collection and reporting requirements, and maintaining current outcomes and performance of the multiple service delivery systems operated by the Collaborative agencies. Other specific measures included, but were not limited to, adequacy of information systems, state and federally required data collection and reporting, capacity for timely and accurate provider payments, sufficient provider networks for Medicaid beneficiaries, and ensuring capacity for providing access on a statewide basis.

The SE was expected to demonstrate mechanisms for maximizing resources and for improving availability and access to culturally relevant services, particularly in rural and frontier areas. The BH Contractor was also expected to produce critical customer/family outcomes and to adhere to delineated system performance requirements.

o. ____ Periodic comparison of number and types of Medicaid providers before and after waiver

p. **X** Profile utilization by provider caseload (looking for outliers)

The New Mexico Omnicaid system generates reports that are analyzed by the Quality Program Integrity Unit. These reports profile Medicaid provider utilization trends for outlier identification. Those BH providers identified as outliers are targeted for closer investigation by the Medicaid Fraud & Abuse staff to evaluate whether further investigation or referrals are indicated to the State’s Medicaid Fraud Unit within the Attorney General’s office. HSD will require that the SE continue this process from SFY07 forward.

q. **X** Provider Self-report data
   - **X** Survey of providers
   - ____ Focus groups

The EQRO performed an annual evaluation of the BH Medicaid provider network’s satisfaction with the SE. State staff reviewed the findings to evaluate whether targeted corrective action plans are indicated

r. ____ Test 24 hours/7 days a week PCP availability

s. **X** Utilization review (e.g. ER, non-authorized specialist requests)
State and EQRO clinical staff performed onsite audits of the BH Utilization Review processes. They perform annual and ad hoc audits as indicated for INPT, RTC and other services involving prior authorization or utilization review monitoring. The EQRO performs quarterly audits of all Medicaid BH service denials using the New Mexico Medicaid definitions of BH denials of care.

The Collaborative will require that the SE continue this process from SFY06 forward.

Other: (please describe)
Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State’s Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request. The State provides below the results of monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, which was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

- Yes
- No. Please explain:

Summary of results:

Problems identified:

Corrective action (plan/provider level)

Program change (system-wide level)
Strategy: Access and Availability Monitoring

During the course of the current waiver, access to care and availability of care were monitored in a multiple ways as follows:

1. **Review the Statewide Entity’s (SE) quarterly submission of their provider facility networks.** The numbers of certain provider types were compared each quarter and others were compared on an ad-hoc basis. The results demonstrated that comparable numbers of contracted providers were present compared to the previous New Mexico model.

2. **Review the SE’s quarterly behavioral health geo-access reports shows inpatient psychiatric hospitalization, partial hospitalization, outpatient therapy facilities/clinics, psychosocial rehabilitation, accredited residential treatment centers – EPSDT, non-accredited residential treatment centers and group homes – EPSDT, treatment foster care I and II – EPSDT, day treatment program – EPSDT, case management – EPSDT SED and at-risk for SED, case management – adult SDMI, and psychiatrists.** The State worked with the SE on both provider network and geo-access reports, the format for which was revised in order to make the reports more useful.

3. **Conduct periodic behavioral health recipient surveys that contain questions concerning recipient access to services and other related consumer satisfaction factors:** The State requires an annual recipient survey to be coordinated by the SE which contains questions concerning recipient access to services and other related consumer satisfaction factors: A behavioral health consumer satisfaction survey was conducted as an SE contract requirement during the spring 2006. The methodology utilized for the survey administration was identical to the method used by New Mexico Medical Assistance since 1999. Listed below are survey summary results from the domains of access to care, satisfaction of care, and appropriateness of care from SE 2006 surveys for both the adult and child populations. The next consumer survey will be completed before the end of July 2007.

4. **An Independent Assessment (IA) was initiated last spring to assess the SE’s performance in the areas of access to care, quality of care and cost effectiveness. The final IA report will be submitted to CMS six months prior to the waiver expiration.**

**Confirmation it was conducted as described:**

- [X] Yes
- [ ] No. Please explain:

**Summary of results:** Each of the mechanisms for monitoring access and availability of services were conducted during this waiver period. The following section addresses the performance of each monitoring technique.

Below are 2006 consumer satisfaction survey data that demonstrate the level of consumer satisfaction with services delivered during the first year of the BH waiver in FY 2006. Medicaid managed care-specific BH data was compared to several years of previous Mental Health Statistical Improvement Project (MHSIP) results, which demonstrated comparable as well as
favorable results. These results will be taken out to several communities around the State for discussion purposes through focus groups.

Problems identified: None
Corrective action (plan/provider level) None
Program change (system-wide level) None

**FY 2006 NEW MEXICO MHSIP ADULT SURVEY DEMOGRAPHICS**

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New Mexico MHSIP Adult Medicaid Trends Over Several Years

2006 New Mexico MHSIP Children and Families Survey Demographics

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Child/Family Gender Results

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### Ethnicity

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### Child/Family Ethnicity

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<td>Outcomes</td>
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### MHSIP Child and Family Medicaid Trends Over Five Years

![Graph showing trends](image-url)
5. **Measure waiting periods to obtain health care services:** The MHSIP survey contains questions regarding prompt access to services as well as questions regarding access to psychiatrist and responsiveness by serving providers when contacted by telephone. As shown above, the vast majority of members responded favorably to the access to care survey statement.

6. **Review client requests for disenrollments from an MCO:** A Medicaid beneficiary who is required to enroll in the statewide entity’s managed care behavioral health service delivery system may request to be disenrolled from managed care to fee for service (FFS) behavioral health services “for cause” at any time. Client disenrollments were not an issue during this waiver period though clients do have the option of disenrollment from the managed care benefit and transition over to fee-for-service benefits. Since ValueOptions is the sole contractor in New Mexico for all publicly-funded behavioral health services, the contractor is responsible for service provision in both systems.

**Strategy:**

**Confirmation it was conducted as described:**

- [X] Yes
- [ ] No. Please explain:

**Summary of results:** During this waiver period, there were no requests initiated for disenrollments from VONM managed care contract to fee-for-service.

**Problems identified:** None

**Corrective action (plan/provider level):** None

**Program change (system-wide level):** None

7. **Review of referrals and authorizations:** The SE is required to report monthly on behavioral health prior authorization data, including requests for services, approvals, administrative and clinical denials, reductions of care, and terminations of care for the following service categories: inpatient psychiatric hospitalization services for adults and children, residential treatment services, and treatment foster care I and II. These are analyzed for any trends that require further investigation with the State and the SE.

**Strategy:**

Confirmation it was conducted as described:

- [X] Yes
- [ ] No. Please explain:

**Summary of results:** Historically, Medicaid has looked at denials for requested Medicaid services. The department receives regularly submitted managed care reports that include total number of requests, approvals, clinical denials, terminations of care, reductions of care as well as administrative denials. These data are tracked and trended per individual covered service to ensure requests for services are being comparably managed by SE to the former prior authorization practices.
The services reported by the SE reflect those that require prior authorization processes per the SE’s discretion. The tracking and trending, in particular, is monitoring for any real time evidence of access to care barriers or systems’ issues. Additionally, periodic denial audits are performed by the EQRO to ensure that the Level of Care Criteria and the Medicaid definition for medically necessary services are applied appropriately and consistently.

Additionally, the State has monitored approvals and denials per 1000 compared to baseline behavioral health prior authorization data from FY 2005, during the previous waiver period. The FY06 Medicaid managed care rate of denials per 1,000 requests (18.56 denials/1,000 requests) did not increase above the previous year’s average, FY05 (20.29 denials/1,000 requests). Table 1 displays the number of denials (by type of denial), total requests for service (includes approvals, denials, and pends), and the denial rate (administrative and clinical denials).

Table 1.

<table>
<thead>
<tr>
<th>Managed Care</th>
<th>Qrt 1 FY 06</th>
<th>Qrt 2 FY 06</th>
<th>Qrt 3 FY 06</th>
<th>Qrt 4 FY 06</th>
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</thead>
<tbody>
<tr>
<td>Total Requests for Service</td>
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<tr>
<td>Clinical Denials</td>
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<td>35</td>
<td>67</td>
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<td>217</td>
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<tr>
<td>Administrative Denials</td>
<td>16</td>
<td>46</td>
<td>111</td>
<td>71</td>
<td>244</td>
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<tr>
<td>Denial Rate per 1,000 service requests*</td>
<td>5.05</td>
<td>13.73</td>
<td>23.87</td>
<td>28.52</td>
<td>18.56</td>
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</table>

*Denial rate per 1,000 service requests = (clinical denials + administrative denials)/total service Requests X 1,000.

The SE held daily rounds and peer review consultation as the strategies to internally monitor the utilization review process. The increase in both clinical and administrative denials was related to improving the understanding of provider contracts by the clinical staff and working with providers to understand the authorization process and the necessary information in reviewing cases.

Problems identified: None
Corrective action (plan/provider level) None
Program change (system-wide level) None

8. Review of the numbers of emergency room visits: The number of ER visits is a HEDIS measure. Most recent HEDIS results to follow.

Strategy:
Confirmation it was conducted as described:

- - Yes
  ____X____ No. Please explain: The State did not require the SE to submit HEDIS data.

There were some quarterly performance measures, which resembled some BH HEDIS measures such as follow up after acute psychiatric hospitalization. Data did not undergo the HEDIS auditing process, thus the SE results cannot be compared to the national benchmarks or the New Mexico HEDIS baseline results from previous years. There was no measure related to ER visits captured or required.
Summary of results: None  
Problems identified: None  
Corrective action (plan/provider level) None  
Program change (system-wide level) None

9. Tracking of complaints and grievances: Complaints and grievance data are submitted to the State regularly. During the first year, the report was submitted monthly. Year 2, this report is submitted quarterly. The top four categories of behavioral health complaints and grievances must be reported with the report findings/analysis. Complaints and grievances report data are used to identify any evidence of systems’ trends or problems that require intervention or monitoring.

Strategy:
Confirmation it was conducted as described:

☐ Yes
☐ No. Please explain:

Summary of results: During the annual 2006 BH compliance audit, the EQRO performed review of the policies and procedures to ensure the process of submitting a grievance were in accordance MAD regulations. In addition, the policies and procedures were examined to determine if VONM resolved grievances within mandated time frames. If the grievance involved clinical issues, such as timeliness of care, access to care or appropriateness of care, the evaluation included a review of the clinical judgments involved in the case. One section of this review included a random sample file review of grievance, appeal and expedited appeals for compliance with MAD regulations. Below are the findings of compliant elements and non-compliant elements:

The overall member grievance resolution standard was determined to be minimally compliant based on the comprehensive review of the VONM grievance system compared to the MAD regulations. The following finding reflected the area of non-compliant components of the grievance review:

- Non-compliant: Policy and procedures for grievances included inappropriate timeliness requirements and did not include portions of the MAD regulations

Problems identified: Policy and procedure for timeliness of grievance resolution was not congruent with the MAD requirements as defined in the regulations

Corrective action (plan/provider level): Any area of non-compliance identified in the annual compliance audit resulted in the need for a corrective action plan. The following was VONM’s proposed CAP intervention to address the deficiencies:
### Grievances 8.305.12

<table>
<thead>
<tr>
<th>.12.10 General Requirements for Grievance and Appeals</th>
<th>Policy and procedure for resolution of grievance and appeals</th>
<th><strong>Policy and procedure for resolution of grievance and appeals</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Revise P&amp;P CL303 to include expedited appeal process.</td>
<td>• Revision complete. P&amp;P CL303 Med Nec Determination to be approved 12/18/06.</td>
<td></td>
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<tr>
<td>• Revise Clinical Appeals P&amp;P and Admin Appeals P&amp;P to include timeliness requirements and recent reg changes.</td>
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</tr>
<tr>
<td>• Revise Consumer Grievance and Provider Grievance P&amp;Ps to include timeliness requirements and recent reg changes.</td>
<td>• Complete. Approved 11/27/06.</td>
<td></td>
</tr>
<tr>
<td>• Finalize Provider Appeals P&amp;P; include recent reg changes.</td>
<td>• Draft completed; to be approved 12/11/06.</td>
<td></td>
</tr>
</tbody>
</table>

### Program change (system-wide level) None

10. **Oversight Team Report Analysis Process:** HSD/MAD clinicians as well as other State agency staff review reports submitted by the SE on a monthly and/or quarterly basis on specific behavioral health indicators, including service authorizations of behavioral health services, service denials of care for behavioral health services, provider payment timeliness and behavioral health complaints and grievances for monitoring access to care, quality of care and/or health and safety issues trends that require attention.

**Strategy:**
Confirmation it was conducted as described:

- [x] Yes
- [ ] No. Please explain:

**Summary of results:** Since the initiation of this contract’s implementation, a cross-agency team of clinicians met twice weekly for four-hour meetings to review, analyze and monitor SE reports as well as other oversight tasks. The behavioral health indicators listed above were monitored closely for any evidence of trends.

Additionally, during the annual 2006 compliance audit the EQRO audited VONM’s reporting processes. The Reporting Requirement’s standard was determined to be minimally compliant during the compliance audit based on MAD regulations. The process to submit accurate, timely reports was non-compliant as required per MAD regulation.
The following were the EQRO recommendations for the deficiency identified:

- Formalize a tracking process for submission of reports to HSD
- Document and track multiple versions of the same report submitted to HSD

**Problems identified:** VONM data reports required for submission to MAD did not have a compliant process for tracking the submission of multiple versions of the same report.

**Corrective action (plan/provider level):** Any area of non-compliance identified in the annual 2006 compliance audit resulted in the need for a corrective action plan. The following was VONM’s proposed CAP intervention to address the deficiencies:

<table>
<thead>
<tr>
<th>14.10.A. Reporting standards</th>
<th>Process to submit accurate, timely reports to HSD</th>
<th>Finalize P&amp;P on report submission process. Include procedures for documentation of submissions.</th>
<th>To be finalized and approved by 12/18/06.</th>
</tr>
</thead>
</table>

**Program change (system-wide level)** None

**Strategy: State Complaint and Grievance System**
HSD’s Complaints & Grievances Data Analysis: During the first year, the complaints and grievance report was submitted monthly. Year 2, this report is submitted quarterly. The department as well as the cross-agency team monitors and utilizes the SE complaint and grievances for identification of potential systems’ issues.

**Confirmation it was conducted as described:**

- Yes
- No. Please explain:

**Summary of results:**
This summary represents an example of the quarterly analysis of the SE complaints and grievances during the first four months of the contract implementation. The grievance report has been modified to a quarterly report but continues to be a tool for monitoring SE operations to identify any potential trends.

The number of grievances received by VONM decreased in October FY 06 as shown in table 2 from 25 grievances in September to 13 in October. The number of grievances referred to VONM from HSD also decreased from 2 grievances in September to 0 in October. The majority of grievances received in October were reported by providers (61.5%) which mirrors the same pattern as grievances received in September (64.0%) but contrasts July (40%) and August (23.8%) data.
Table 2. Number and type of grievances reported by VONM between July and October FY 06 and compared against HSD baseline data (July thru October FY 05)

<table>
<thead>
<tr>
<th></th>
<th>HSD Baseline FY 05</th>
<th>VONM FY 06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jul</td>
<td>Aug</td>
</tr>
<tr>
<td>BH Consumer Grievances Received</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>BH Provider Grievances Received</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>8</td>
</tr>
</tbody>
</table>

In Table 3, there were two categories of grievances that warranted tracking for possible systems’ issues. In the consumer grievance report, it was identified that quality of care appeared to be a possible issue. In the provider grievance report, it appeared that claims issues were the dominant provider grievance.

Table 3. Types of VONM consumer and provider grievances by reporting quarter (FY 06).

<table>
<thead>
<tr>
<th>Consumer Grievances</th>
<th>3rd Quarter FY06</th>
<th>4th Quarter FY06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>14</td>
<td>60.9%</td>
</tr>
<tr>
<td>Pharmacy Formulary/Prior Auth</td>
<td>4</td>
<td>17.4%</td>
</tr>
<tr>
<td>Claims Issues</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>4</td>
<td>17.4%</td>
</tr>
<tr>
<td>Consumer Services</td>
<td>1</td>
<td>4.3%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total # of Consumer Grievances</strong></td>
<td>23</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Grievances</th>
<th>3rd Quarter FY06</th>
<th>4th Quarter FY06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Claims issues</td>
<td>10</td>
<td>76.9%</td>
</tr>
<tr>
<td>Pharmacy Formulary/Prior Auth</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Consumer Services</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Access to Care</td>
<td>1</td>
<td>7.7%</td>
</tr>
<tr>
<td><strong>Total # of Provider Grievances</strong></td>
<td>13</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

**Problems identified:** Issues related to provider claims processing and client complaints regarding “quality of care” were identified. A cross-agency team of fiscal staff performed an audit and identified claims processing issues during these reporting quarters. The quality of care complaints were related to a residential provider that triggered a series of cross-agency audits that resulted in a sanction. Close continued monitoring by the CYFD licensing and certification unit has continued. Regarding the claims issues, the cross-agency team required corrective action plans.

**Corrective action (plan/provider level):** EPSDT residential provider sanction was initiated, which warranted a corrective action plan as well as a bed capacity freeze. VONM submitted
corrective action plans related to its claims processing issues identified by the State fiscal staff. The VONM claims processing department held a summit, which resulted in the revision of the claims processing policies and procedures and the Enrollment/Billing Manual. Provider liaisons, claims processors, and other VONM staff attended the summit and have had ongoing participation in the development of the manual and resulting clarification of billing and claims processing issues. Providers are continually ‘trained’ on these issues through meetings with provider liaisons, regional directors, and other staff.

**Program change (system-wide level):** None

**Strategy:** Enrollee Call Center operated by State  
**HSD’s 4th quarter 2006 Telephone Hotline Data:**  
The following 4th quarter FY06 data represents New Mexico Medical Assistance Call Center activity. These internal monthly data are tracked and trended for evidence of increased client calls made to Medicaid toll free lines related to any potential systems’ issue.

**Confirmation it was conducted as described:**  
_X_ Yes  
___ No. Please explain:

**Summary of Results: HSD’s Telephone Hotline Data Analysis:**  
The behavioral health-related telephone data remained stable with 0% of the calls received by the New Mexico Medical Assistance Call Center as being related to behavioral health.

<table>
<thead>
<tr>
<th>Medicaid Call Center Data</th>
<th>April 06</th>
<th>May 06</th>
<th>June 06</th>
<th>4th Qtr. Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH-Related Calls</td>
<td>23</td>
<td>38</td>
<td>32</td>
<td>93</td>
</tr>
<tr>
<td>Non-BH Related</td>
<td>15259</td>
<td>17,242</td>
<td>17,257</td>
<td>49,758</td>
</tr>
<tr>
<td>i) Percentage of the 4th quarter FY 06 BH calls</td>
<td>0 percent</td>
<td>0 Percent</td>
<td>0 percent</td>
<td>0 percent</td>
</tr>
</tbody>
</table>

**Problems identified:** None  
**Corrective action (plan/provider level):** None  
**Program change (system-wide level):** None

**Strategy: Capacity Standards**

The Collaborative receives a quarterly network update from the SE, which includes changes from the previous quarter. The networks are reviewed quarterly by the Collaborative.

**Confirmation it was conducted as described:**  
_X_ Yes  
___ No. Please explain:

**Problems identified:** See above  
**Corrective action (plan/provider level):** See above  
**Program change (system-wide level):** See above
Strategy: Enrollment Capacity and Open Panels
The State has monitored to ensure that enrollment limits and open panels were adequate.

The State monitors to ensure that there are adequate open panels within the MCO/PIHP/PAHP:

The SE is required to submit a quarterly GeoAccess report regarding certain types of behavioral health providers including psychologists, psychiatrists and behavioral health providers, which is used to monitor and track the number of managed care providers and their geographic location.

In addition, the SE submits a quarterly provider network update, which includes high volume providers not accepting new clients. The network is reviewed quarterly.

The State ensures that the number of providers under the waiver is adequate to assure access to all behavioral health services covered under the contract:

Confirmation it was conducted as described:

_ X_ Yes
___ No. Please explain:

Problems identified: See above
Corrective action (plan/provider level): See above
Program change (system-wide level): See above

Strategy: Coordination and Continuity of Care Standards
Per HSD/MAD regulations the SE is expected to implement written policies and procedures for governing how members with multiple and complex physical and behavioral health care needs are identified. The SE is expected to have an internal operational process, in accordance with policy and procedure to target members for the purpose of applying stratification criteria to identify ISHCN.

Per HSD/MAD regulations the SE is required to have developed and implemented policies and procedures to ensure access to care coordination for ISHCN. In addition, the MCOs ensure that each member identified as having special health care needs is assessed by an appropriate health care professional regarding the need for care coordination.

Confirmation it was conducted as described:

_ X_ Yes
___ No. Please explain:

Summary of results:
During the annual 2006 compliance audit, the EQRO audited VONM’s Coordination of Services policies, procedures as well as processes for coordinating PH & BH services for ISHCN. The coordination of care standard was determined to be minimally compliant based on MAD regulations. The following findings reflect non-compliant components:

- Educational materials for behavioral health providers relating to the referral process for physical health consultation was not submitted; State-wide training occurred detailing the transition from the managed care organizations (July 1, 2005) to VONM; however, training documents submitted did not include referrals for care coordination
- Provider handbook and the provider newsletter were reviewed for care
coordination in relation to topics concerning referrals for physical health and behavioral health services

- Sample plan of care did not indicate interventions, community planning and information sharing with multiple providers
- The process for the development and implementation of the plan of care by the case manager or community case manager was inconsistent in the review of care coordination cases
- Results from the specific care coordination case reviews demonstrated a 53% compliance rate

The following were the EQRO recommendations for the deficiencies identified:
- Develop and include coordination of services as a component of educational briefings during a provider site visit
- Include specific referral information in the provider handbook
- Develop a VONM care coordination form to capture the required information related to care coordination issues and include the behavioral health plan of care components
- Develop education materials for distribution when ISHCN are identified with a particular problem or to assist members, caregivers, parents, and/or legal guardians
- Formalize and distribute ISHCN clinical practice guidelines to providers
- Develop and implement policy and procedure for utilization management to include services for ISHCN
- Develop performance measures specific to ISHCN

Problems identified: See above

Corrective action (plan/provider level):
VONM developed and started implementing a corrective action plan to address care coordination and ISHCNs. Some of the interventions are listed below:
- Provider training topics for FY07 include ‘referrals’; Training Plan submitted to Oversight Committee 9/06.
- New provider orientation materials under development; draft modules to be completed and reviewed by 2/1/07.
- Revise internal care coordination plan form to more closely parallel elements defined in the regulations.
- Module will include Clinical Tip Sheet, which includes referral information.

An internal VONM workgroup dedicated to improving identification of ISHCNs (and other Special Populations), stratification, and care coordination processes continues to make progress. A comprehensive project management plan has been developed. The plan addresses policies, care coordination guidelines, documentation, training, internal audits, identification reports, stratification tool, and targeted outreach for care coordination services.

Program change (system-wide level): See above

Strategy: Coordination and Continuity of Care Monitoring
Standards for continuity and coordination of care are monitored through:
- External quality review organization quality audit (annually);
- Review provider manuals (initial contract and upon revision);
- Review member handbooks (initial contract and with each revision);
- Perform SE medical record audit (periodically, as indicated);
- Review of SE policies and procedures regarding coordination (initial contract and periodically thereafter);
- Monitor grievances and complaints (upon receipt to resolution and through review of monthly reports);
- Review SE provider education programs (beginning of contract year);
- Review SE plans for determining network provider compliance; and

For members participating in HCBS Waivers, HSD/MAD:
- Review SE policies and procedures for coordination with the Developmental Disabilities, Medically Fragile, Disabled and Elderly, and HIV-AIDS Waiver programs;
- Conducts annual audits of SE performance related to coordination through the external quality review organization;
- Monitors complaints and grievances (upon receipt to resolution and through review of monthly reports;
- Communicates with and receives feedback from Department of Health and HSD staff who administer DD programs. Separate DD/Mentally Ill Adult and DD/Mentally Ill children workgroups have been established to address issues, including coordination, related to these specific populations;
- Participates in several other interagency and statewide provider/State agency workgroups, such as the Children’s Behavioral Health Sub-Committee, to problem-solve and coordinate among all parties involved in serving high risk children and families; and
- Reviews provider and consumer surveys conducted by the State and/or the SE.

The SE must have and implement policies and procedures regarding coordination with the schools for those members receiving services excluded from managed care as specified by an Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). This coordination is intended to ensure that members receive medically necessary services, which compliment the IEP or IFSP services and promote the highest level of function for the child.

Confirmation it was conducted as described:

X Yes

No. Please explain:

Summary of results: The oversight team monitored the internal care coordination system within the SE throughout this contract period. It was apparent early on that the SE required significant technical assistance with this function. The State clinical staff have worked diligently to assist the SE with the understanding of the internal care coordination process as well as monitoring its ongoing implementation.

Additionally, there are care coordination workgroups with representatives from the SE, the Salud! physical health MCOs and other stakeholders such as Child Protective Services to address the care coordination needs of special at-risk populations.