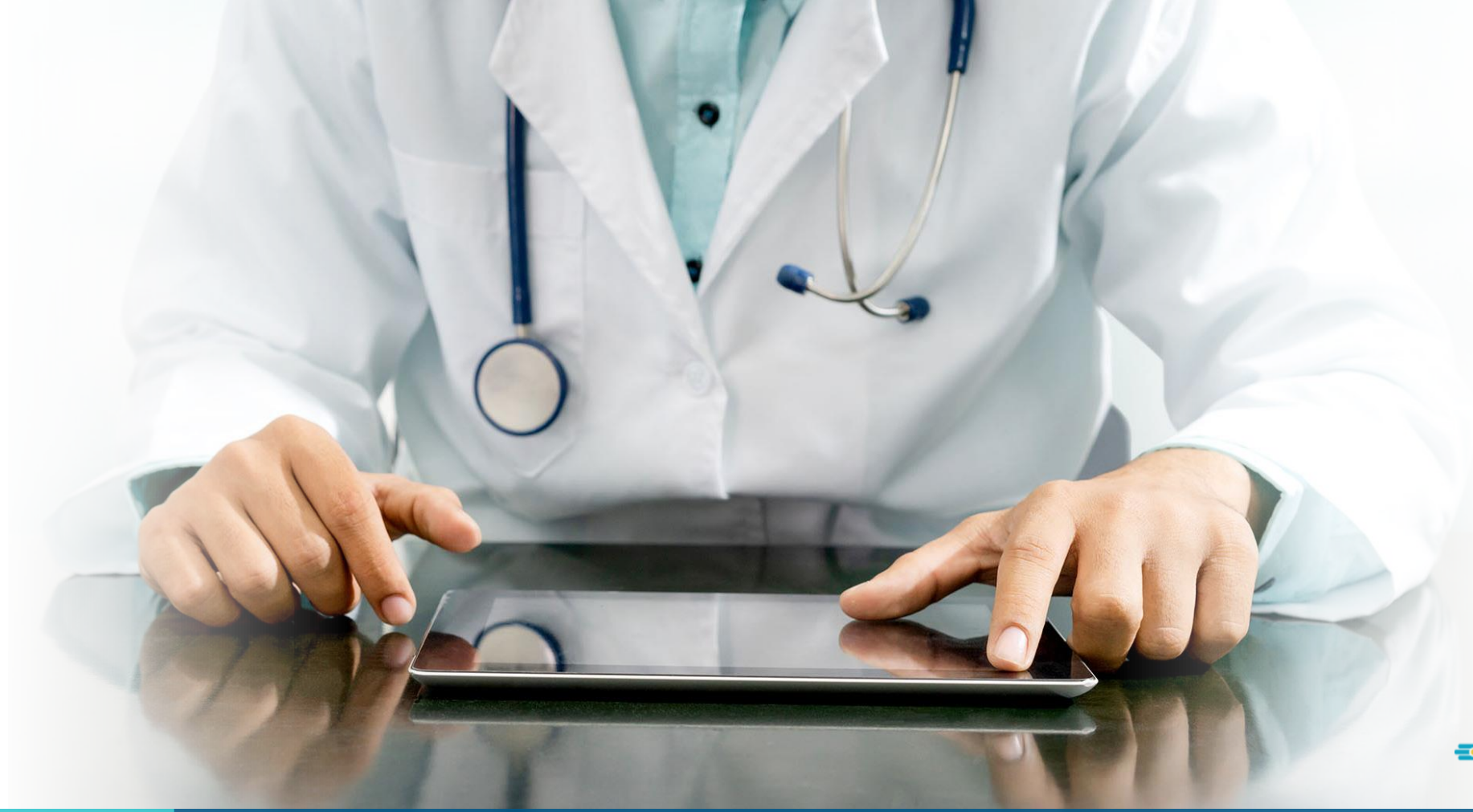


BlueCross BlueShield of New Mexico

Primary Module

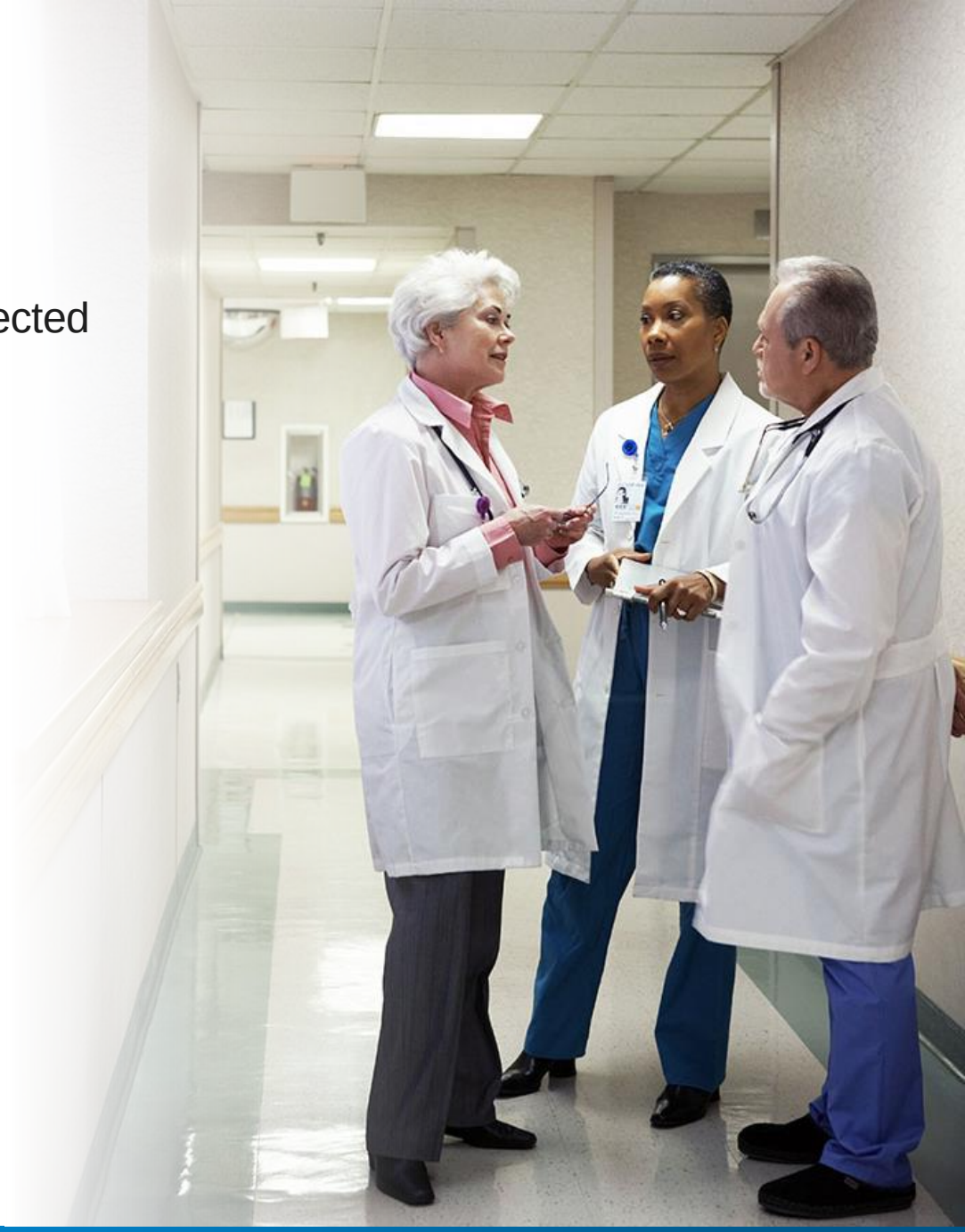
Blue Cross Community Centennial℠ • Provider Training • 2023

Such services are funded in part with the State of New Mexico. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, and/or copayments/coinsurance are subject to change. Blue Cross and Blue Shield of New Mexico complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

About Today's Agenda: Provider Responsibilities

This training is intended for providers only. Members should be directed to the Blue Cross and Blue Shield of New Mexico (BCBSNM) Centennial Member Handbook. This training, and the material presented herein, is accurate as of the date of publication and is subject to change. Please refer to the BCBSNM website and other source documents for updates.

Nothing in this training constitutes medical advice. Providers will exercise their independent medical judgement in rendering care to members. All providers referenced in this training are independent from and not employed by BCBSNM.



Agenda

Participating with BCBSNM

- Provider Reference Manual (PRM)
- Registering as a Managed Care Provider
- Onboarding and Credentialing
- Disclosure of Ownership and Control Interest Form
- Verify and Update Your Information
- Obligation to Provide Access to Care

Covered Services

- Integrated Care
- Alternative Benefit Plan (ABP)
- Pregnancy and Family Planning Services/Special Beginnings®
- Value-Added Services
- Project ECHO
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefits
- Non-Emergency Medical Transportation (NEMT)
- Supportive Housing
- Substance Use Disorder and Serious Mental Illness

Prior Authorizations

- Carelon and Carelon Provider Portal
- Availity®
- Referrals

Claims and Billing

- Timely Filing
- Best Practices
- Recoupment Information

Provider Resources

- BCBSNM Provider Website
- Provider Reference Manual
- Specialized Trainings
- Blue Review℠ Provider Newsletter
- How to Access Providers

Member Rights and Responsibilities

- Member Enrollment
- Member Services
- Ombudsman
- Primary Care Physician (PCP) Assignment
- ID Cards

Quality Improvement Program and Initiatives

Appeals and Grievances

- Internal Provider Appeal/Grievance Process
- Provider Responsibilities

Critical Incident Reporting

Care Coordination

- Health Risk Assessment (HRA)/Comprehensive Needs Assessment (CNA)
- Integrated Care
- Improving the Delivery System

Cultural and Linguistic Competency

- Annual Cultural Competency Training Requirement
- Resources

Fraud, Waste and Abuse

High-Volume Providers

Participating with BCBSNM

Additional Information

- Provider Reference Manual – The PRM lists all provider responsibilities and is an extension of a provider's contract with BCBSNM.
  - There is a list of key phone numbers in the "Contacts List" section
  - It contains complete lists of Covered Services
  - The content in the PRM is subject to change due to new federal or state regulations or new requirements or a Letter-of-Direction from the New Mexico Human Services Department (HSD)
- Members' Rights and Responsibilities
- Cultural Linguistics
- Fraud, Waste and Abuse
- Today's Training Presentation
  - This information is also subject to change due to new federal or state regulations or new requirements from HSD
  - Provider Training Modules may be found on our website: bcbsnm.com/provider/training/index.html

Additional Training

All provider training sessions are available on our website: bcbsnm.com/provider/

You can request additional training from your BCBSNM provider representative or complete a self-led review of the materials at your convenience.

Please let us know if there are topics you wish to discuss.

- Behavioral Health
- Cultural Competency Training (annual requirement)
- Depression Screening and Outpatient Provider Incentives
- Dual Special Needs Population (DSNP)
- HEDIS Measures for Quality
- Indian Tribal Urban (ITU)
- Information for Hospitals
- Long-Term Care Services and Support
  - Nursing Facilities
  - Home and Community-Based Services, Agency-Based Community Benefit (ABCB), Self-Directed Community Benefit (SDCB), Electronic Visit Verification (EVV)
  - ABCB Program Recruitment
- Primary Care Provider Responsibilities
- Telehealth
- Pregnancy and Family Planning

Participating with BCBSNM

- Providers applying for network participation with BCBSNM are required to register with the HSD's fiscal agent Conduent
- Must register as a Managed Care-only provider, or as a Fee-for-Service and Managed Care provider
- If a provider fails to enroll, BCBSNM will deny claims – registration ensures that billing and rendering providers can be identified on claims and encounter reports

Four Easy Ways to Register

NM Medicaid Portal

nmmedicaid.portal.conduent.com/static/index.htm

Email

NMProviderSUPPORT@Conduent.com

Phone

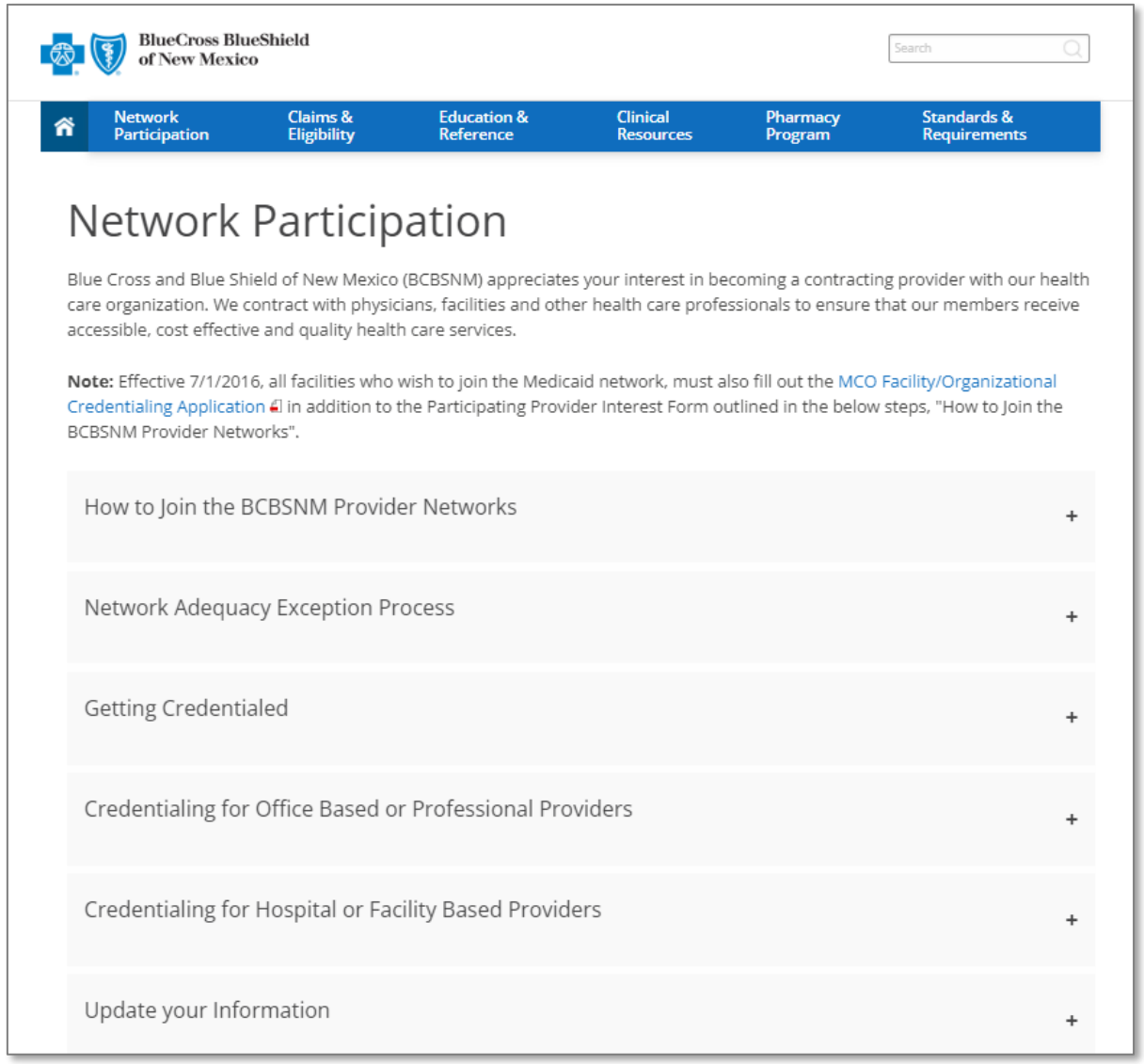
505-246-0710 or 800-299-7304

Fax

505-246-9085

Onboarding Process

- Process for both typical and atypical providers can be found on our provider website in the Network Participation section.
- Some providers still go through the Participating Provider Interest form (PPIF). PPIFs for both typical and atypical providers can be found on our provider website in the Network Participation section.



bcbsnm.com/provider/network-participation/network-participation/credentialing

Disclosure of Ownership and Control Interest Form

- Completion and submission is a condition of participation as a credentialed or enrolled provider
- Form needs to be completed by the disclosing solo practitioners or the disclosing contracting entity
- Find this form at bcbsnm.com/pdf/forms/provider_disclosure_form.pdf

Submit the Disclosure of Ownership and Control Interest Form

- With your Managed Care Organization (MCO) application
- At initial and renewal of a contract or agreement
- Any time there is a revision to the information
- Within 35 calendar days of a request for the disclosure
- Within 35 calendar days of a change in ownership

Provider Re-Credentialing

- The process of re-credentialing is similar to the initial credentialing process and is completed every 3 years. The provider can continue servicing members until otherwise notified.
- CAQH will send providers a notification every 120 days instructing them to confirm the information is accurate and complete on their website: caqh.org/solutions/caqh-proview-providers-0

Provider Credentialing – CAQH Application

- Initial Credentialing with BCBSNM requires:
  - Compliance with all credentialing requirements to include, but not limited to, an active license that has not been revoked, terminated, probated or suspended
- Site Visits
  - Facilities and practitioners may require a site visit
  - BCBSNM will contact the provider to schedule and conduct site visits

Failure to maintain credentialing status can result in provider termination from all networks.

Verify and Update Your Information

Beginning Jan. 1, 2022, the federal Consolidated Appropriations Act (CAA) of 2021 **requires that certain provider directory information be verified every 90 days.**

This means you must:

- Verify your name, specialty, address, phone and digital contact information (website) for our provider directory every 90 days, and
- Update your data when it changes, including when you join or leave a network
- Under CAA, we're required to remove providers from our Provider Finder® whose data we're unable to verify
- If you leave a network, you should continue to update your information immediately and according to your contract terms. If you are incorrectly identified as an in-network provider in Provider Finder, it may limit member cost-sharing to in-network levels. Learn more about the CAA

We won't accept demographic changes by email, phone or fax to enable us to meet the two-day directory update requirement defined by the CAA.

How to Verify and Update Your Information

Availity Provider Data Management
(recommended for professional providers)

- Changes **professional providers** can make in Availity include:
  - Personal information
  - Service location address change
  - Doing Business As (DBA) name
  - Payment address change and contact information
  - Hours of operation
  - Business website URL

Demographic Change Form
(required for facilities)

- Changes **providers and facilities** can make with the Demographic Change Form include:
  - Legal Name
  - NPI/Tax ID
  - Directory information:
    - Office physical address
    - Telephone
    - Fax
    - Email
    - Hours of operation
  - Billing contact information
  - Credentialing contact information
  - Administrative contact information
  - Provider roster information (removing a provider from the group or location)

Obligation to Provide Access to Care

The following appointment availability and access guidelines should be used to ensure timely access to medical, dental and behavioral health care.

Primary Medical Care / PCP, Dental and Laboratory Appointment Standards	
Routine Asymptomatic	For routine, asymptomatic, member-initiated, outpatient appointments for primary medical care, the request-to-appointment time shall be no more than 30 calendar days, unless the member requests a later time For routine, asymptomatic member-initiated dental appointments, the request-to-appointment time shall be no more than 60 calendar days, unless the member requests a later date
Routine Symptomatic	For routine, symptomatic, member-initiated, outpatient appointments for non-urgent primary medical and dental care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time
Urgent	Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours
Specialty	For specialty outpatient referral and consultation appointments, excluding behavioral health, the request-to-appointment time shall generally be consistent with the clinical urgency, but no more than 21 calendar days, unless the member requests a later time

Obligation to Provide Access to Care (cont.)

Appointment Availability and Timely Access Requirements

Diagnostic Laboratory / Imaging and Pharmacy Prescriptions	
Diagnostic Laboratory/ Imaging	For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time shall be consistent with the clinical urgency, but no more than 14 calendar days, unless the member requests a later time For outpatient diagnostic laboratory, diagnostic imaging and other testing, if a “walk-in” rather than an appointment system is used, the member wait time shall be consistent with severity of the clinical need For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability shall be consistent with the clinical urgency, but no longer than 48 hours
Pharmacy/ Prescriptions	The in-person prescription fill time (ready for pickup) shall be no longer than 40 minutes; a prescription phoned in by a practitioner shall be filled within 90 minutes

Behavioral Health Appointment Standards	
Routine	For non-urgent behavioral health care, the request-to-appointment time shall be no more than 14 calendar days, unless the member requests a later time
Urgent	Primary medical, dental and behavioral health care outpatient appointments for urgent conditions shall be available within 24 hours
Crisis Services	For behavioral health crisis services, face-to-face appointments shall be available within 2 hours

Covered Services

Alternative Benefit Plan (ABP)

The Alternative Benefit Plan is a part of the New Mexico Medicaid Centennial Care program.

The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 138% of the Federal Poverty Level (FPL), which includes the Medicaid Expansion Population and Transitional Medical Assistance categories.

ABP Covers:

- Doctor Visits
- Preventive Care
- Hospital Care
- Emergency Department
- Urgent Care
- Specialist Visits
- Behavioral Health Care
- Substance Abuse Treatment
- Prescriptions
- Certain Dental Services
- And more …

Alternative Benefit Plan

Individuals may choose to receive services under the ABP or Standard Medicaid if they have any of the following:

- Serious or complex medical condition
- Terminal illness
- Chronic substance use disorder
- Serious mental illness
- Disability that significantly impairs their ability to perform one or more activities of daily living (ADL)

Members will be covered by ABP unless they meet criteria and choose to move to the Expansion State Plan/ABP Exempt Plan.

Pregnancy and Family Planning Services

- Pregnancy-related care and family planning services are Covered Services that do not require prior authorization. Members may self-refer for care.
- Family Planning includes pregnancy testing and counseling. Members may self-refer to contracted *and non-contracted* family planning providers in New Mexico. Family planning providers include PCPs, OB/GYNs, Planned Parenthood clinics and Department of Health clinics.
- Coverage due to pregnancy only: Some women are eligible for Medicaid because they are pregnant. Coverage is for pregnancy and the postpartum period through 12 months after the date of delivery.

Special Beginnings

- Any pregnant member can opt-in for Special Beginnings and is encouraged to be screened for Special Beginnings Care Coordination services.
- Registration for Special Beginnings includes general pregnancy education, access to important resources and information on how to obtain pregnancy related Value-Added Services.
- Special Beginnings Care Coordination services are available at no cost to BCBSNM members who have been screened and are determined to be an expectant mother.
- The BCBSNM Special Beginnings team is comprised of experienced registered nurses, social workers and health coordinators who strive to offer members access to and coordinate timely interventions by contracted providers during and after pregnancy.
- In addition, the BCBSNM Special Beginnings team also has specialized NICU Transition of Care team that works closely with neonate and family to not only facilitate the inpatient stay, but to ensure safe transition home to include vital services that need to be in place with eventual permanent transition to Care Coordination.
- Providers can directly refer members to NMCNTLSpecialBeginnings@bcbsnm.com or provide the email for a self-referral.
- Program information can also be found on the BCBSNM Special Beginnings website: bcbsnmcommunications.com/special_beginnings/2054953/483419.html

Value-Added Services: Physical Health

Value-Added Services (VAS) are not Covered Services and are not Medicaid-funded. There are no appeal rights for these services. VAS differ for ABP members and members on the standard Medicaid plan (Centennial Care) and are subject to change.

Value Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value Added Service?
Physical Health Services					
Home Meal Delivery	Members who are transitioning from an inpatient facility into the community	✓	✓	✓	No
Native American Traditional Healing and Wellness (reimbursement for traditional healing practices used to treat medical conditions)	Native American members	✓	✓	✓	No
Remote Monitoring Program	Members with chronic conditions like diabetes or high blood pressure	✓	✓	✓	Member must participate in the Paramedicine Program; requires an assessment
Respite Bed (temporary bed based on medical necessity and availability)	Certain members discharging from an emergency room or hospital	✓	✓	✓	Yes
Assistance with Social Determinants of Health* (payments for tangible goods such as interview clothing, bus passes for work and more)	Medicaid and Medicaid Expansion Population members	✓	✓	✓	Yes

Value-Added Services: Physical Health and Maternity

Value-Added Services (VAS) are not Covered Services and are not Medicaid-funded. There are no appeal rights for these services. VAS differ for ABP members and members on the standard Medicaid plan (Centennial Care) and are subject to change.

Value Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value Added Service?
Physical Health Services					
Walmart Delivery Service*	Medicaid and Medicaid Expansion Population members-one per household	✓	✓	✓	Yes
Heading Home + Health Partnership*	Bernalillo County Homeless Members with Behavioral Health and Substance Abuse Disorders	✓	✓	✓	Yes
Maternity Services					
Infant Car Seat*#	Pregnant members	✓	✓	✓	Yes
Portable Infant Crib*#	Pregnant members	✓	✓	✓	Yes

Value-Added Services: Behavioral Health

Value Added Service	Applies To	Members on Standard Medicaid Plan	Members on Alternative Benefit Plan (ABP)	Members on ABP-Exempt Plan	Prior Authorization Required for Value Added Service?
Behavioral Health Services					
Electroconvulsive Therapy (ECT) treatment for psychiatric conditions	Members who meet standard ECT medical necessity criteria	✓	Not a Value Added Service; standard ABP benefits apply	Not a Value Added Service; standard benefits apply	Yes
Transitional Living for Chemically Dependent/ Psychiatrically Impaired Adults 18 years or older	Members enrolled in outpatient substance abuse center or in active treatment for psychiatric issues	✓	✓	✓	Yes
Wellness/Drop-in Centers and Family Support Centers	Medicaid members	✓	✓	✓	No
Assistance with Social Determinants of Health* (payments for tangible goods such as interview clothing, bus passes for work and more)	Medicaid and Medicaid Expansion Population members	✓	✓	✓	Yes
Heading Home + Health Partnership*	Bernalillo County Homeless Members with Behavioral Health and Substance Abuse Disorders	✓	✓	✓	Yes
Learn to Live	Medicaid and Medicaid Expansion members 13 years or older	✓	✓	✓	No

*Must participate in BCBSNM's Care Coordination program to redeem

Reminders about Newborns

- When a child is born to a mother enrolled with Blue Cross Community Centennial, a Notification of Birth form must be submitted by the hospital or other Medicaid provider prior to or at the time of discharge, to ensure that Medicaid-eligible newborn infants are enrolled and medically covered as soon as possible.
- It is very important for the mother to call the New Mexico Human Services Department ISD caseworker to notify them of the newborn. (They should also call ISD if they have adopted a child or wish to place their child for adoption.)
- **Please do not submit claims for a newborn with the mother's identification (ID) number.**

Project ECHO® Endocrinology Program

Project ECHO is a movement to demonopolize knowledge and amplify the capacity to provide best practice care for underserved people all over the world. The endocrinology program will provide collaborative feedback, recommendations and evidence-based endocrine education through brief lectures and case discussions.

Case Discussions and Curriculum

Each week an endocrine topic will be presented, and case examples will be introduced by Tele-ECHO participants. Topics include complex diabetes, thyroid disease, adrenal and pituitary disorders, hypogonadism, polycystic hyperlipidemia and transgender health.

Target Audience

Anyone supporting patients with endocrine disorders, including physicians, advanced practice providers, pharmacists, nurse practitioners, nurses, community health workers, social workers and other health care personnel.

How to Participate

- Email endoecho@salud.unm.edu to receive session announcement and connection information.
- Participate in case discussions and brief lectures.
- Complete the online survey after the session to receive CME, CPE, CNE, ASWB and CHW no-cost credits.

Well-Child Health Check

The EPSDT well-child checkup may include the following:

- Physical Screening
- Medical Screening
- Developmental/Behavioral Screenings
- Nutritional Screening
- Immunizations
- Lead Testing
- Hearing/Vision and Dental Exams
- School-Based Services
- Private Duty Nursing
- Personal Care Options
- Other necessary health care or diagnostic services

The New Mexico Tot-to-Teen Health Check Schedule:

- Under age 1: 6 screenings (birth,1, 2, 4, 6 and 9 months)
- Ages 1-2: 4 screenings (12, 15, 18 and 24 months)
- Ages 3-5: 3 screenings (3, 4 and 5 years)
- Ages 6-9: 2 screenings (6 and 8 years)
- Ages 10-14: 4 screenings (10, 12, 13 and 14 years)
- Ages 15-18: 4 screenings (15, 16, 17 and 18 years)
- Ages 19-20: 2 screenings (19 and 20 years)

What is EPSDT?

- Provides comprehensive and preventive health care services for children under age 21
- Helps children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services

Early
Assessing and identifying problems early

Periodic
Checking children's health at periodic, age-appropriate intervals

Screening
Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems

Diagnostic
Performing diagnostic tests to follow up when a risk is identified

Treatment
Control, correct or reduce health problems found

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit Requirements

EPSDT Services: Where to Go

EPSDT Skilled Services	EPSDT Personal Care Services (PCS)
Requested by the Member's Provider	**Requested by Member and Care Coordinator**
Private Duty Nursing, Physical Therapy, Occupational Therapy, Speech Therapy: To make a request, the servicing agency calls into the Utilization Management (UM) Intake department at **877-232-5518** (the servicing agency must have a provider order to initiate the request). If approved, an authorization will be issued to the servicing agency.	The member's assigned care coordinator will submit the request and required documentation to UM for review/approval. The member will also need to select a PCS agency prior to submission.
Outpatient Therapies are reviewed by Carelon**.** Utilizing the Carelon Provider Portal is the most efficient way to initiate a case, check status, review guidelines, view authorizations/ eligibility and more:https://www.providerportal.com/ OR call the Carelon at **800-859-5299.**	**Required Documentation:** ADL age-appropriate Assessment Tool, supplemental notes, EPSDT PCS allocation tool, PCS/Agency selection and a PCP order.
All codes that require prior authorization are posted on the PA grid, differentiated by AIM and internal review. The criteria and medical documentation needed is listed on the PA grid at bcbsnm.com/docs/provider/nm/cc-pagrid-07012022.pdf	EPSDT PCS providers should be registered as a provider type **324- Nursing Agency, Private Duty**

Non-Emergency Medical Transportation

Non-Emergency Medical Transportation (NEMT) is a Covered Service for all Centennial Care BCBSNM members. ModivCare is our contracted vendor.

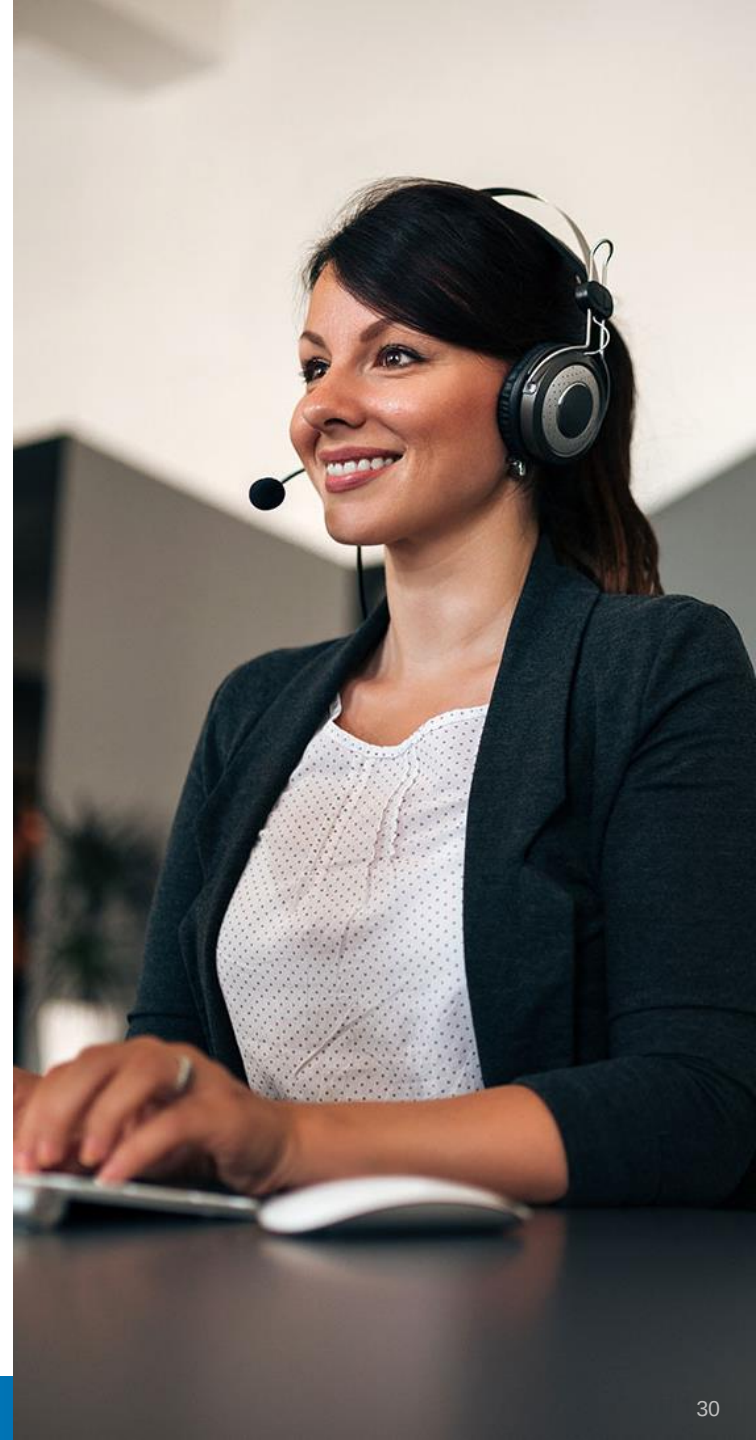
- ModivCare provides rides to and from medical appointments or mileage reimbursement. Special needs are accommodated.
- ModivCare may obtain or ask the member (or member's parent or representative) to obtain verification that an appointment has taken place.
- NEMT helps to lower appointment "no-shows."
- NEMT is NOT for emergencies or transfers between facilities, cannot be used for trips to a pharmacy. NEMT can be coordinated for "non-emergent" discharges from a facility, clinic, etc.
- NEMT can also be used to request a standing order such as dialysis or chemotherapy.
- Members are educated to make a reservation at least three days in advance by calling **866-913-4342**.
    - To return home, members call **866-418-9829** after their appointment. They may also call this number to get a ride to Urgent Care after hours or check status of a transportation reservation.

Supportive Housing

BCBSNM has a housing specialist to help members find resources.

- Finding and applying for housing
- Checking that the living area is safe and ready for move-in
- Getting necessary household supplies
- Creating a housing plan
- Coaching on how to keep good relationships with neighbors and landlords
- Coaching about how to follow rules from the landlord
- Education on renter's rights and responsibilities
- Assistance in fixing renter issues
- Regular review and updates to housing plan
- Help finding community resources to keep the house or apartment in working order

To receive this service, members must meet certain requirements.
To find out if a member qualifies for these services, please call the
BCBSNM Supportive Housing Specialist at **877-232-5518.**



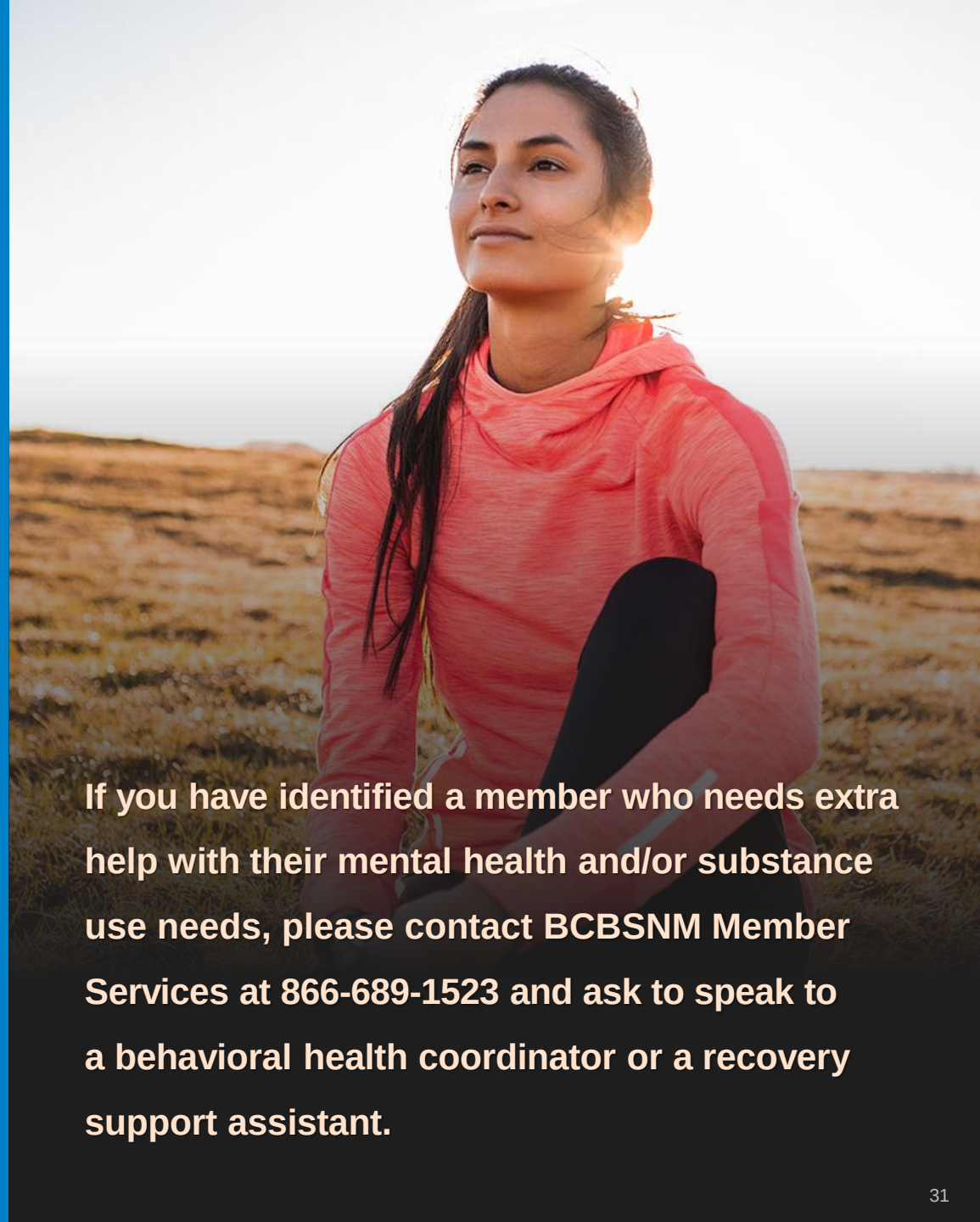
Identification of Substance Use Disorder and Serious Mental Illness

BCBSNM has internal peer support specialists who can help engage members with complex needs.

- They use their lived experiences to help members meet their treatment goals and try to engage them in required treatment.
- They can help providers identify needed resources for members who struggle with mental health and substance use needs.

BCBSNM has liaisons in all psychiatric facilities. These liaisons help facilities and members with discharge planning to identify gaps, barriers and resources.

They make sure appointments are set and help with any needed transportation. Their goal is to help members with a more successful discharge back to the community.



If you have identified a member who needs extra help with their mental health and/or substance use needs, please contact BCBSNM Member Services at 866-689-1523 and ask to speak to a behavioral health coordinator or a recovery support assistant.

Prior Authorization

Prior Authorization

- Unless otherwise prohibited by law, prior authorizations are required for certain services before they are rendered. Prior authorizations are based on:
  - Benefits and medical necessity
  - Nationally recognized, peer-reviewed, evidence-based criteria
  - New Mexico Administrative Code (NMAC)
  - Other nationally recognized medically necessary care guidelines
- Long-Term Supports and Services (LTSS) have different prior authorization requirements.
- Native Americans are exempt from the prior authorization process when using Indian Health Service, Tribal or Urban Indian (I/T/U) facilities.

Prior Authorization Requirements

- Prior authorization requirements are listed in the Precertification Section of the Provider Reference Manual on the BCBSNM provider website: bcbsnm.com/docs/provider/nm/bcbsnm-provider-reference-manual.pdf
- Providers can also search for prior authorization requirements for Medicaid members using our digital lookup tool.
- Prior authorization criteria are reviewed annually by the BCBSNM medical directors.
- Providers are notified of changes to prior authorization criteria at least 30 days in advance of implementation.

Prior authorizations *(with the exception of LTSS services)* can be obtained:

1. By calling **877-232-5518, option 2**
2. By faxing the **NM Uniform Prior Authorization Form** found on our provider website at bcbsnm.com/pdf/forms/nm-uniform-pa-form.pdf to 505-816-3854
3. **Availity:** availity.com
4. **Carelon**: https://www.providerportal.com/

Carelon Medical Benefits Management

BCBSNM has contracted with Carelon to provide pre-service authorization for various services.
Please visit our website for a complete list of procedures which require prior authorization through Carelon.

Please use Availity for all other services that require a referral and/or preauthorization.

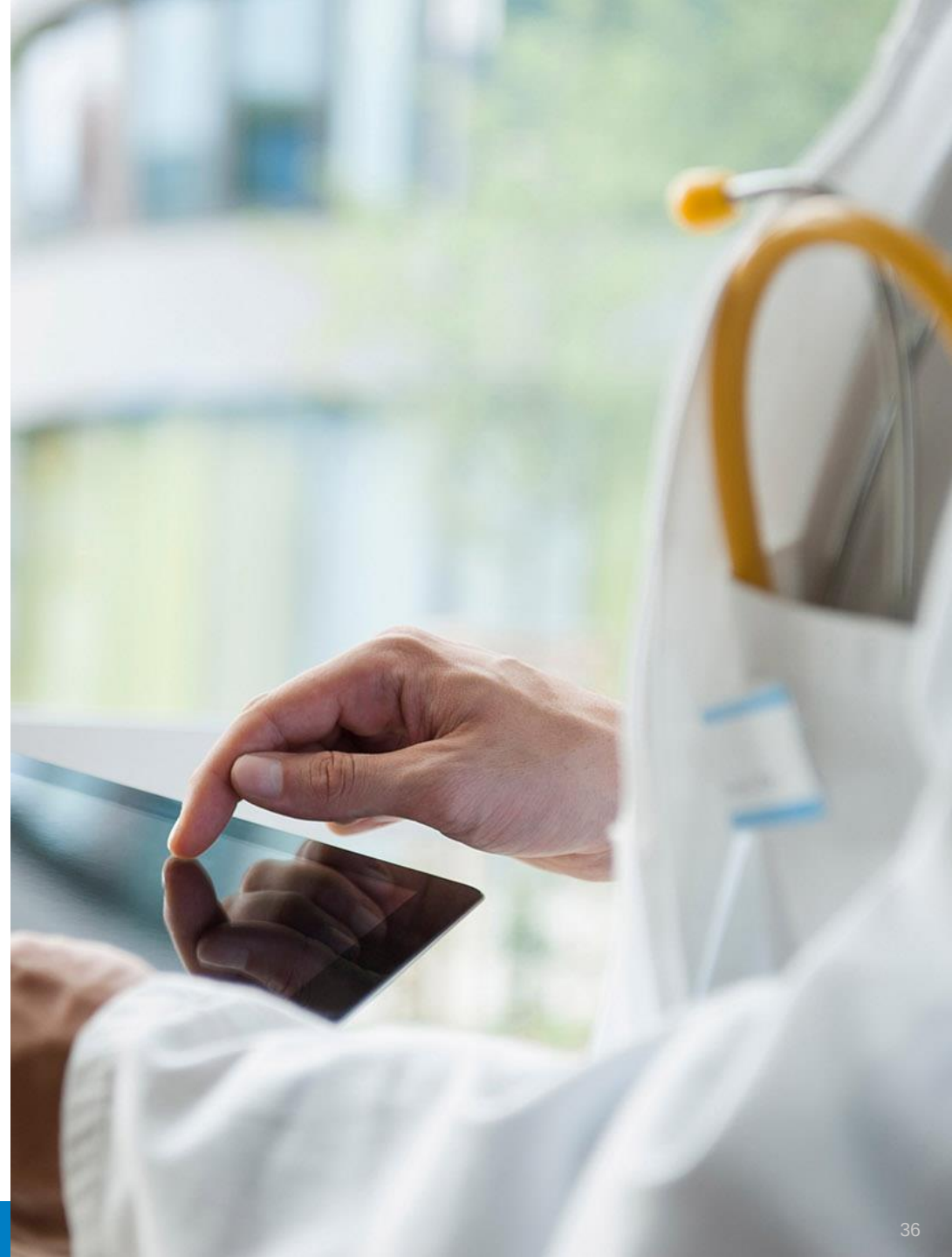
Services performed without preauthorization may be denied for payment, and the rendering provider may not seek reimbursement from members.

The Carelon web portal is available 24/7.
Please call **800-859-5299**
8 a.m. – 5 p.m., MST, M-F

Prior Authorization: Hospitalizations

Please notify BCBSNM at **877-232-5518** regarding:

- Elective hospitalizations
- Emergent hospitalizations – in the event the service is due to an emergency, or following a visit to the Emergency Department, the facility must notify BCBSNM within 1 working day of the admission



Prior Authorization Compliance

BCBSNM complies with applicable legal and accreditation requirements for prior authorizations, including, but not limited to, the New Mexico Prior Authorization Act and NCQA, such that BCBSNM accepts the standard prior authorization form promulgated by the New Mexico Office of Superintendent of Insurance and makes prior authorization decisions within:

- 7 business days after receipt of standard request
- 24 hours after receipt of expedited request

It is critical that the provider furnish all relevant documentation and information in support of the request, because we will make a decision based on what we have by the time of the deadline for a decision.

For select categories: Radiology, Molecular Genetics, Outpatient PT/OT/ST, Spine, Joint and Pain, Radiation Therapy, Sleep, Medical Oncology PA requests should be sent to Carelon which may have minimally different processes that remain compliant with all applicable laws and accreditation requirements, see https://www.providerportal.com/ for more information.

Referrals

- BCBSNM does not require a referral when members see any in-network medical, behavioral or long-term care provider.
- Referrals are also not needed for:
  - Emergency services
  - EPSDT services
  - Women’s services
  - Vision
  - Dental
- Members can request a second opinion from a provider in the Blue Cross Community Centennial Care network without a referral:
  - Prior authorization may be necessary based on the type of service
  - Prior authorization from BCBSNM is required to see an out-of-network provider
  - Third or fourth opinions require prior authorization from BCBSNM

Claims and Billing

Timely Filing of Claims

- Claims should be filed within 90 days; **must file no later than 180 days**.
- If there is a primary carrier, timely filing requires (1) filing with the primary carrier within 180 days from the date of service; and (2) filing with BCBSNM within 180 days from the date of the primary Explanation of Benefits (EOB). The primary carrier EOB must be attached or the information from the EOB must be entered in Availity.
- If there is not a primary carrier and no documentation furnished that the claim was sent to the wrong carrier within 180 days from the date of service, all claims submitted after 180 days from date of service will be denied.
- I/T/U providers have up to two years from the date of the service to file claims.

Claims Submission Best Practices

Member Information

- Name, date of birth and gender
- Member's ID number (as shown on the member's ID card, including the 3-digit alpha prefix YIF)
- Individual member's group number, where applicable

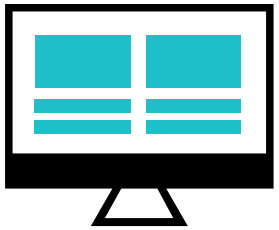
Participating Provider Information

- Provider's Tax Identification Number
- Provider NPI number and Taxonomy (Type 1 and Type 2, if applicable)
- Participating Provider Name and address
- Place of service code
- Preauthorization number, if required

Visit Information

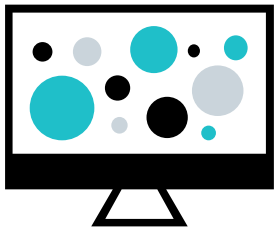
- Indication of:
  - Job-related injury or illness, or
  - Accident-related illness or injury, including pertinent details
- ICD-10 diagnosis codes
- CPT® procedure codes
- NDC codes in accordance with Medicaid requirements
- Date(s) of service(s)
- Charge for each service

How to Submit Claims



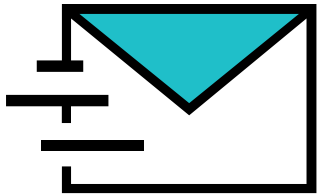
Electronic Submission

- **Payer ID MC721**, effective 05/20/17
- For information on electronic filing of claims, contact Availity at **800-282-4548**



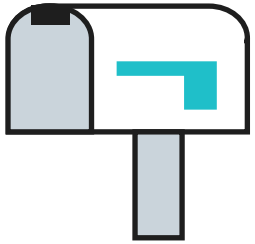
Duplicate Claims

- Verify claims receipt with BCBSNM prior to resubmitting to prevent denials



Paper Submission

- Must be submitted on the CMS-1500 or CMS-1450(UB-04) claim form



Submit forms to:

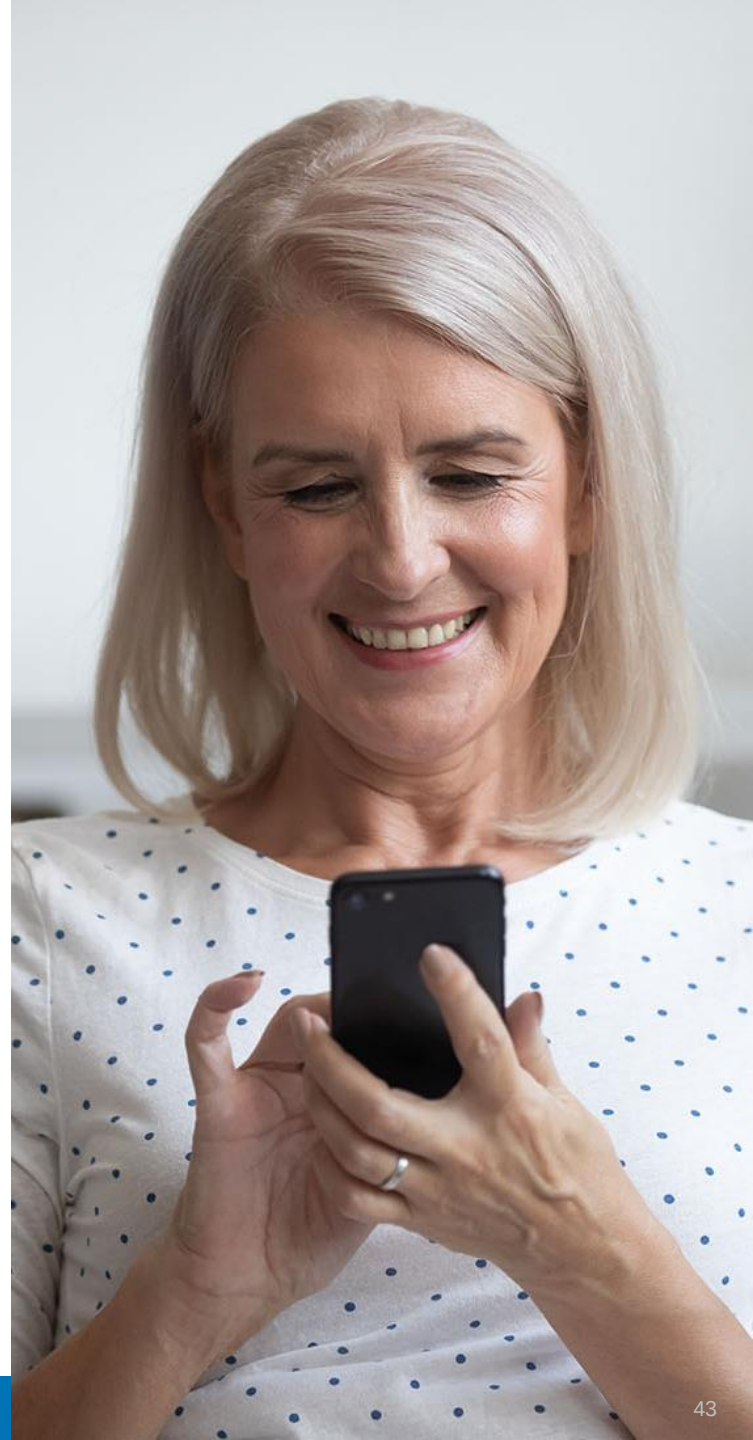
- **Claims:** BCBSNM, P.O. Box 650712 Dallas, TX 75265-0712
- **Appeals:** BCBSNM, P.O. Box 660717 Dallas, TX 75266-0717

Hold Members Financially Harmless

Participating providers and sub-contractors of providers agree that in no event ... will participating providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a member to whom health care services have been provided, or person acting on behalf of the member for health care services provided.

Participating providers are prohibited from collecting any payment for non-covered services from the member.

Providers must not bill members or accept payment from members for non-covered services unless all requirements of Section 8.302.1.16 NMAC have been satisfied: (1) provider advised member before furnishing a non-covered service that it is not covered; (2) provider gave member information about necessity, options and charges for the non-covered services; and (3) member agreed in writing to receive the non-covered services with knowledge that they will be financially responsible for payment.



Reminder about Payment for Admission

- If a member is hospitalized at the time of enrollment, disenrollment or suspension into or from managed care, the payor at the date of admission will be responsible for payment of all covered inpatient facility and professional services provided within a licensed acute care facility, non-psychiatric specialty unit, or hospital until the date of discharge.
- If a member becomes enrolled during the hospital stay, the MCO would be responsible for payment from the member's effective date.
- Upon discharge, the member becomes the financial responsibility of HSD or the MCO.

Additional Claims Reminders

Coordination of Benefits (COB)

- Blue Cross Community Centennial is always the payer of last resort
- Claims should be submitted with the complete primary insurance Explanation of Benefits
- For members with both Medicare and Medicaid, Medicare is considered the member's primary insurance

Encounter Reporting

- BCBSNM is required by HSD to report ALL services rendered to Centennial Care members

Billing Audits

- We will conduct both announced and unannounced site visits and field audits to contracted providers defined as high-risk (providers with cycle/auto-billing activities, providers offering durable medical equipment (DME), home health, behavioral health and transportation services) to ensure services are rendered and billed correctly

National Drug Code (NDC)

11-digit NDC, units of measure and units are all required:

- When billing for injections/other drug items on CMS1500 and UB04 claim forms, and 837 electronic transactions; HSD requirement as of Sept. 2010
- When reporting injections/other drug items administered in outpatient offices, hospitals and other clinical settings on CMS1500 and UB04 claim forms, and 837 electronic transactions, per the Federal Deficit Reduction Act of 2005 (signed 2006)

Recoupment Information

Should an auto-recoupment occur from a future payment, the Provider Claim Summary will show the following:

- Patient name, patient account number (if available), BCBSNM group and member number
- Overpaid claim number, dates of service, amount taken and an abbreviated overpayment reason
- It may be necessary to offset an overpayment from multiple checks

Please save your recoupment letters to assist you in balancing your payments. Overpayments can be returned to:

Blue Cross and Blue Shield of New Mexico
Attention: Collections Department
P.O. Box 27630
Albuquerque, NM 87125-7630

Additional Claim Information

- Do not submit unsolicited medical records – wait for request and only submit the information requested.
- **High Dollar** (claims that will pay $100k or greater), Assistant Surgeon, and other claims may require an itemized statement and/or medical records. A letter will be mailed that explains exactly what is needed and the records/itemized statement should be mailed or faxed with that letter.
- Do not submit medical records via Availity – records can be faxed or mailed and should be submitted with the letter that requested the records.
- **Provider Claim Summaries (PCS)** can be found in Availity, Electronic Remittance Advice (ERA), or will be mailed to address on file. Please reconcile your accounts prior to calling Customer Service for claim status. Provider who have hired Third-party vendors can grant access to Availity for purposes of checking claim status.

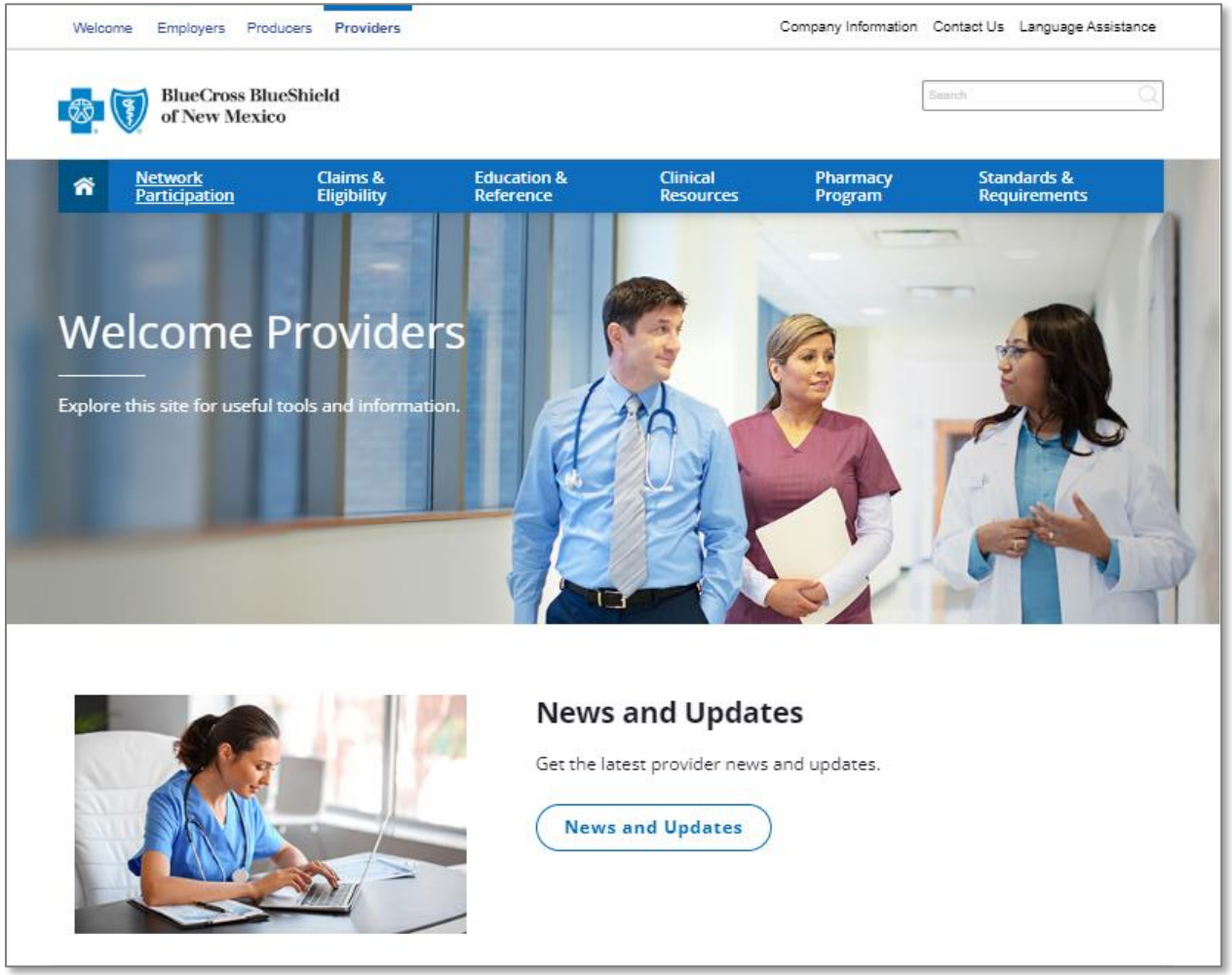
Provider Resources

Provider Resources

- **BCBSNM's provider website** offers many resources, trainings and information for our providers at bcbsnm.com/provider/
- **Update** your demographic information
- Review our Provider Reference Manual **(PRM)**
- Access and/or request **specialized training**
- Review and/or sign up for our monthly Provider Newsletter, **Blue Review**
- BCBSNM **Provider Representatives** are organized by geographical region and provider type.

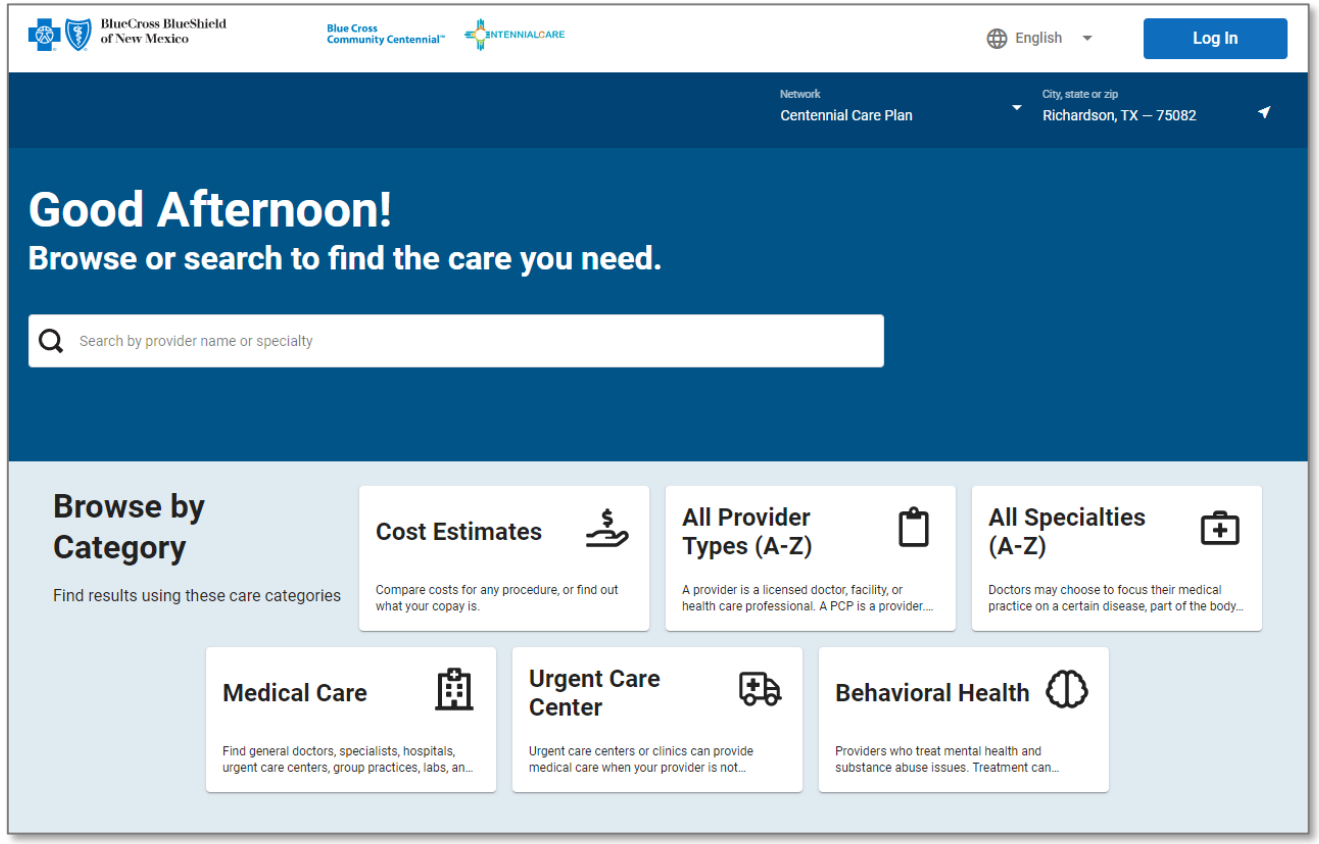
For the most up to date list of Provider Representative assignments, please visit

https://www.bcbsnm.com/provider/contact-us



How to Find In-Network Providers

- Search our online and printed p**rovider directories**
- Select the appropriate “Plan,” **Blue Cross Community Centennial**
- Select the city, state or ZIP
- Browse by **Category** or search by **Provider Specialty**
- Results can be viewed by “List” or “Map”
- Results can be sorted by:
  - Best Match
  - Distance
  - Quality
  - Rating
  - A-Z
  - Z-A
  - Tier



Member Rights and Responsibilities

Member Enrollment

- Centennial Care income determination and enrollment processes are completed by the Income Support Division of HSD.
- Individuals choose a Managed Care Organization or are auto-assigned* to one.
- Members have the opportunity to change MCOs within the first three months following enrollment. If a member changes MCOs, they will remain with the new MCO until the next open enrollment period.
- Members may submit requests to HSD to change prior to the next open enrollment for unique or special circumstances.

*The percentage of members given to any one MCO is determined by HSD based on factors such as if the MCO is new to Centennial Care, quality measures, cost or utilization management performance or other determinants at HSD's discretion. HSD attempts to assign a new member, e.g. a newborn, to a family member's MCO and returns members to their former MCO within certain time frames. When all of that has been met, then they are randomly auto-assigned.

Member Rights and Responsibilities

Members have specific rights and responsibilities:

- They are educated about them in the Member Handbook, at community events with Community Outreach and at Member Advisory Groups.
- Please review these as they set forth some of the important expectations of your interactions with members.
- Member responsibilities include how they should conduct themselves when dealing with providers and their staff.

Member Services Contact Information

Members may call, write or visit our website for questions regarding Centennial Care. Our phone number is listed on the back of the member ID card.

Phone: 866-689-1523
Members with hearing or speech impediments can call the TTY/TDD line at 711

Write to Member Services:
Blue Cross Community Centennial
P.O. Box 27838
Albuquerque, NM 87125-7838

Website:
bcbsnm.com/community-centennial

Member Handbook:
bcbsnm.com/community-centennial/pdf/cc-member-handbook-nm.pdf

Centennial Care Ombudsman

The BCBSNM ombudsman specialist advocates for members' rights by fairly exploring problems and utilizing Medicaid guidelines and BCBSNM resources at no cost.

Phone:
888-243-1134

Email:
NMCentennialCareOmbudsman@bcbsnm.com

Primary Care Provider Assignment

- Members may select a participating PCP within 15 days of enrollment
- If a PCP has not been selected within 15 days, members will be auto-assigned to a PCP:
  - Members will be auto-assigned to a particular PCP, e.g., PCP is of record for one or more family members
  - Auto-assignment is based on age, gender and ZIP code
- Members may change PCPs at any time for any reason
- Dually Eligible Medicare and Medicaid Members:
  - Members dually enrolled with BCBSNM must select a BCBSNM in-network Medicare Advantage PCP
  - Members not dually enrolled with BCBSNM may see any Medicare-participating PCP and present both ID cards
  - For dually eligible Medicare and Medicaid members, BCBSNM will be responsible for coordinating the primary, acute, behavioral health and long-term care services with the member's Medicare PCP

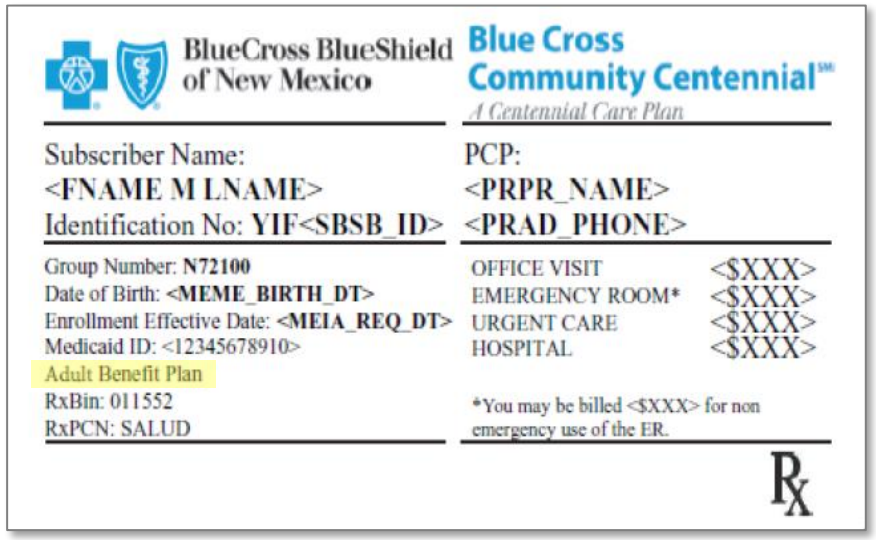
Member ID Cards – Centennial Care and ABP

The front of the card includes:

- Member name
- ID number
- Benefit information
- Type of plan

The back of the card includes:

- Important phone numbers to coordinate services, e.g., transportation scheduling and ride assist
- Prior authorization request instructions



ID Card Guidelines

At each office visit / admission:

- Ask for the member's ID card
- Copy/scan both sides of the ID card and keep the copy with the patient's file
- Determine if the member is covered by another health plan and record information for coordination of benefits purposes, including Medicare coverage
- If the member is covered by another health plan, the provider must first submit the claim to the other carrier(s). After the other carrier(s) pay, submit the claim to BCBSNM.
- A BCBSNM ID card is **not** a guarantee of eligibility. Eligibility should be checked prior to the appointment/procedure.
- Refer to the member's ID card for the appropriate:
  - Telephone number to verify eligibility
  - Copayment specific to the member's coverage/type of plan

Quality Improvement Program and Initiatives

How Continuous Quality (QI) Improvement Works

BCBSNM QI process includes strategies, initiatives and activities to support achievement of the Quality Improvement/Quality Management Program goals and objectives.

Annual Program Evaluation

Reviewed (quarterly, annually and as needed) during internal committee meetings (Quality Improvement Committee (QIC)) for improvement. Evaluate data and current performance.

1. Select new or continued performance improvement projects
2. Prioritize based on criteria
3. Identify an accountable individual
4. Establish timelines, measures and goals

The basis of activity/intervention identification is to ensure activity/ intervention will have a favorable effect and impact on health outcomes and/or on member experience and satisfaction.

QI Work Plan

The QI Work Plan is developed with consideration of BCBSNM's strategic goals and past performance and accomplishments to avoid duplication of efforts and to place focus on efforts and available resources. The strategic plan is developed based on analysis and assessment of the overall program effectiveness, improvement and sustained improvement of activities of the prior year.

Implementation & Monitoring

QI activities and results are shared at staff meetings or through quarterly newsletters. Formal QI teams and workgroups can be formed to address gaps, barriers or identified trends. Quality activities and interventions are discussed with monitoring mechanisms in place to assess outcome effectiveness and improvement.

The monitoring of activities requires frequent cross-departmental discussions fostered through the QIC and/or within other various appropriate committees and/or workgroups.

Continuous Quality Improvement Components

Continuous clinical and service quality improvement activities include, but are not limited to:

- Supporting the provider community through Value Based Contracts with a goal to improve performance on multiple HEDIS measures for attributed membership
  - Monthly joint operating meetings are held with each provider group. Trending scorecards are provided. Additional training for Supplemental Data Submission is provided.
  - HEDIS gap lists of attributed members were provided along with Indices (Analytics Provider Platform) training so that providers can review performance and pull respective gap lists.
  - In addition, to provide feedback on the member experience, member satisfaction performance gathered via CAHPS surveys were shared with provider groups that met the denominator threshold.
- Monthly Quality Improvement Committee meeting held with external provider involvement, sharing both service and clinical quality outcomes while requesting provider perspective on how to mitigate barriers and improve performance (i.e., clinical outcomes and service delivery)

Appeals and Grievances

Appeals and Grievances (A&G)

Appeal

A request for review of an ”action” taken by BCBSNM about a service. An action is when BCBSNM denies, delays, limits or stops a service. This can be regarding a medical, behavioral health, prescription, transportation, vision or dental service.

To file an appeal:

Phone: 800-693-0663

For standard appeals or grievances afterhours, call 877-232-5520.

Fax: 888-240-3004

Write:
Use the form at
bcbsnm.com/pdf/forms/prov-appeal-medicaid-mem.pdf

Grievance

An expression of dissatisfaction by a member or a participating provider about any matter or aspect of BCBSNM, or its Blue Cross Community Centennial operation, e.g., wait times, cleanliness of office, quality of care received, etc.

To file a grievance:

Phone: 800-693-0663

Fax: 888-240-3004

Write:
Blue Cross Community Centennial
Appeals and Grievances
ATTN: Grievance Coordinator
PO Box 27838
Albuquerque, NM 87125-7838

A&G Timeline

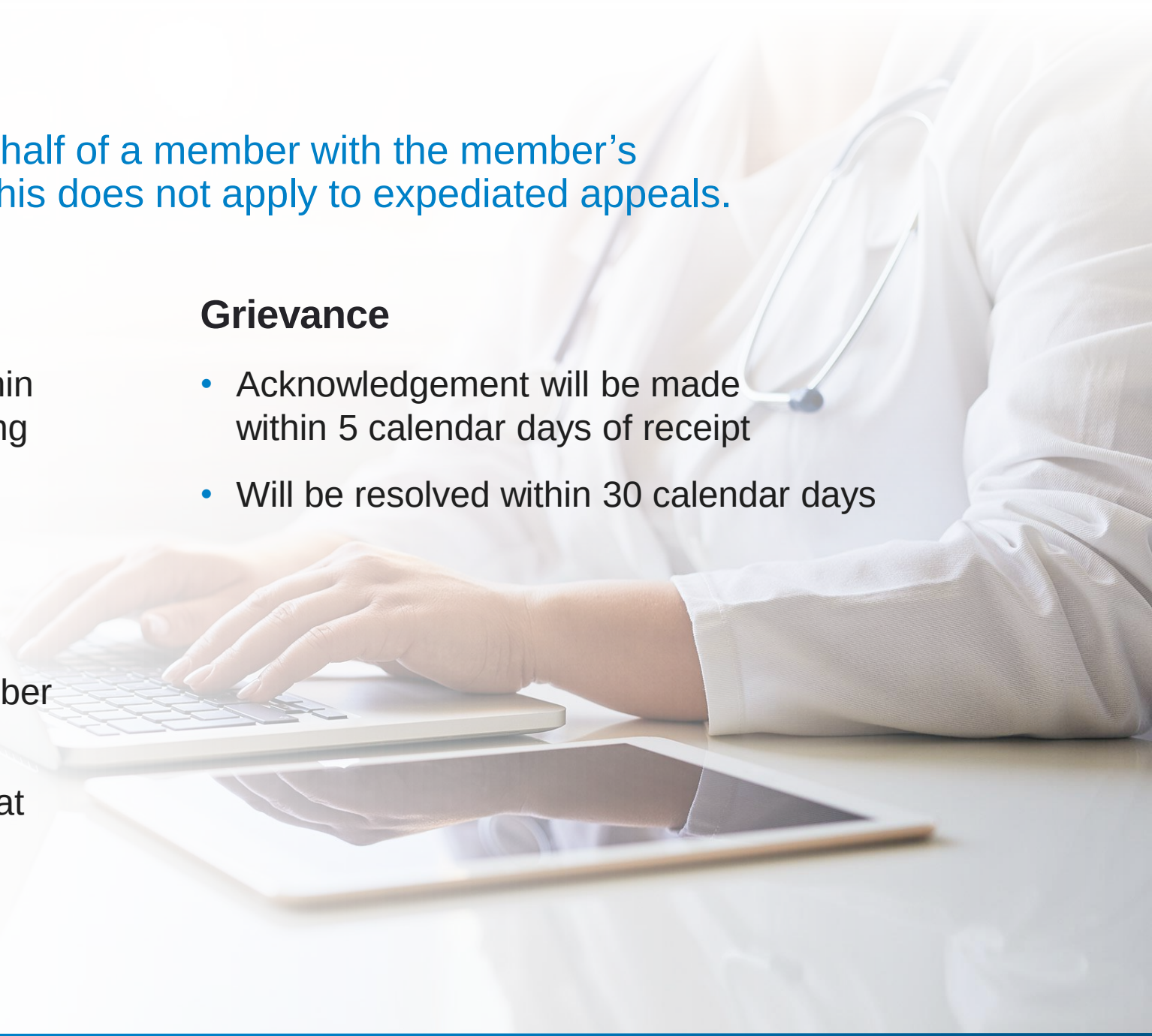
Providers may request an appeal on behalf of a member with the member's authorization for pre-service appeals. This does not apply to expediated appeals.

Appeal

- Need to be requested by the provider within 60 calendar days from the date of receiving the notice of action
- Acknowledgement will be made within 5 calendar days of receipt
- Will be resolved within 30 calendar days unless it is in the best interest of the member to extend the time by 14 calendar days
- HSD must approve extension requests that are requested by the plan

Grievance

- Acknowledgement will be made within 5 calendar days of receipt
- Will be resolved within 30 calendar days



Internal Provider Appeal or Grievance Process

- When the A&G Department receives an appeal or grievance from a provider, it is electronically or manually date stamped to indicate the corporate received date.
- The A&G Department sends a written acknowledgement letter to the provider within 5 business days.
- The A&G staff ensure that the person who reviews and resolves the appeal was not involved in the initial determination.
- The A&G staff conducts an investigation and notifies the provider if an extension is required.
- The A&G staff send a resolution letter to the provider within 30 calendar days.
- The A&G staff updates the electronic system with the resolution information.

Appeals and Grievances – Provider Responsibilities

- Providers should instruct the member to contact Member Services at the number listed on the back of the member's ID card if they have a complaint or concern.
- Participating providers must cooperate with BCBSNM and members in providing necessary information to resolve the appeal/grievance within the required time frames.
- Providers need to submit the pertinent medical records and any other relevant information. In some instances, providers must give information in an expedited manner to allow BCBSNM to make an expedited decision.
- Providers cannot use a statement signed by the eligible recipient or their authorized representative to accept responsibility for payment of a denied claim if services have been rendered unless such billing is allowed by HSD Medical Assistance Division rules.

Appeals and Grievances – Provider Responsibilities (cont.)

- Providers must not request an expedited appeal unless the normal 30 days puts the member's health at risk. Blue Cross Community Centennial plan automatically provides an expedited review for all requests related to a continued hospital stay or other health care services for a member who has received emergency services and is still in the hospital.
- Providers need to submit the pertinent medical records and any other relevant information. In some instances, providers must give information in an expedited manner to allow BCBSNM to make an expedited decision.

Critical Incident Reporting

Critical Incident Reporting in the HSD Portal

- Please refer to this section in the Provider Reference Manual
- Allegations of abuse, neglect (including self-neglect), exploitation, deaths (expected and unexpected), emergency services, law enforcement, environmental hazards, and elopement/ missing for select Categories of Eligibility (COEs) must be reported to HSD through the Critical Incident Reporting system portal at criticalincident.hsd.state.nm.us. Additional COEs may be reported outside of the portal.
- If providers suspect abuse, neglect or exploitation of members, they are mandated by law to contact:
  - Adult Protective Services by phone at 866-654-3219 or via fax at 505-476-4913; or
  - Children, Youth & Families Department at 855-333-7233; and/or
  - Contact law enforcement or the appropriate tribal entity
- For more information and helpful training documents on what and how to report, go to hsd.state.nm.us/providers/critical-incident-reporting/

Care Coordination

Care Coordination

The Care Coordination team assists members and their families with accessing services to help meet their health care needs.

Reasons for Care Coordination Referrals include:

- Qualifying change in condition
- Non-compliance with medication or treatment plan
- Untreated or unaddressed medical, behavioral health or substance abuse needs
- Social Determinants of Health (SDH)
- Polypharmacy (use of six or more different medications)
- Concerns regarding Self-Directed Community Benefits (SDCB)
- A patient in need of community benefits, such as but not limited to Personal Care Services, Behavior Support and Assisted Living
- Assistance managing care for complex needs and disease management

The Care Coordination team consists of:

- Non-clinical member care coordinators and health coordinators
- Clinical care coordinators with health care backgrounds: registered nurses, social workers (LMSW, clinical SW) and others
- Community health workers
- Peer Support Specialists

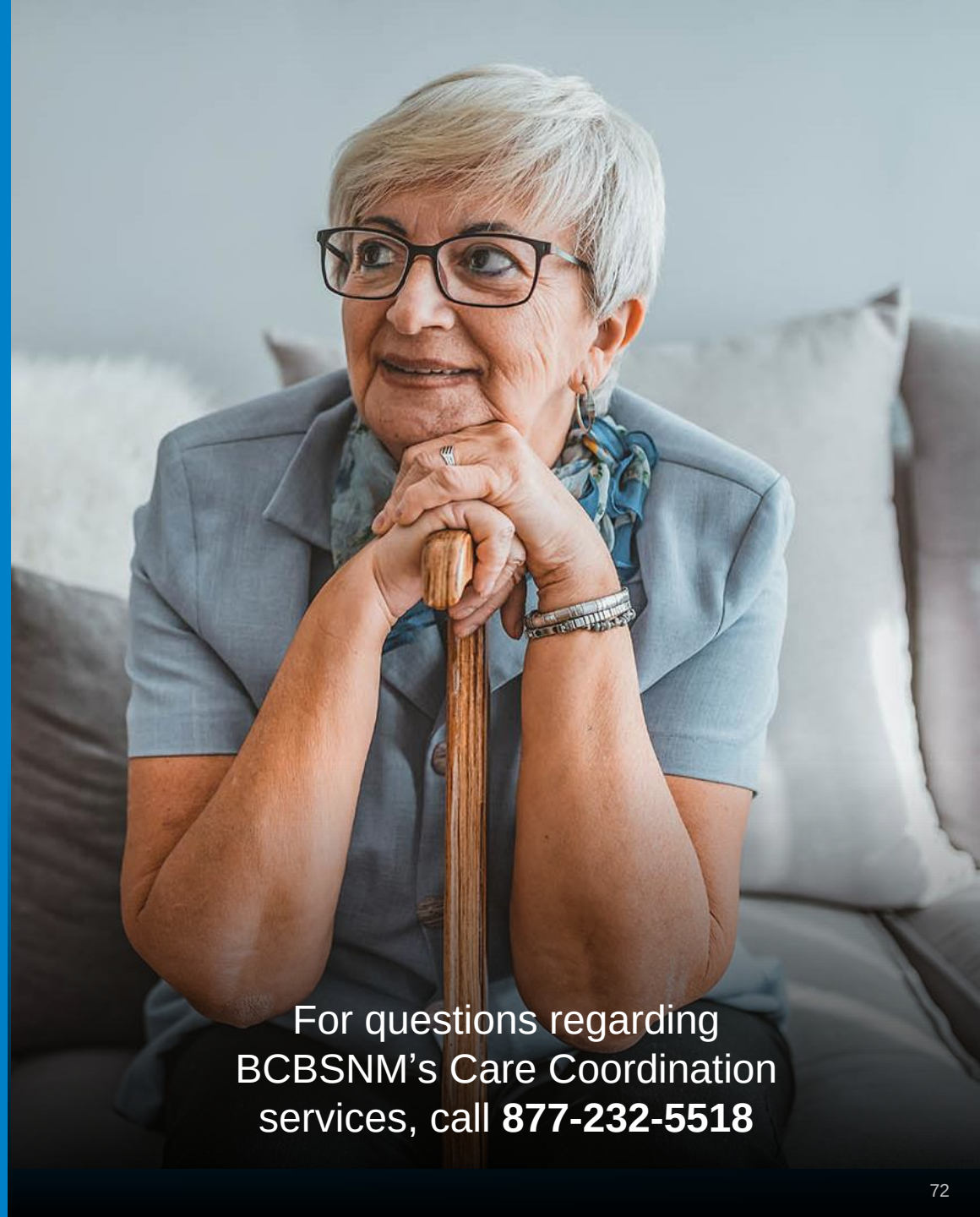
Types of Care Coordination

Longitudinal Care Coordination

Members with chronic conditions that are not stable and/or complex social issues

Complex Care Coordination

- Assists members with complex needs
- Members will be assigned a complex care coordinator if they:
  - Have co-occurring or comorbid health condition needs
  - Focusing on needs, support and guidance for treatment decisions
  - Coordinate services and care among active treatment providers
  - Examine daily lifestyle and choices that impact diagnosis
  - Find resources in the community
  - Answering questions about treatment, medications, and overall health
  - Identify warning signs of relapse and developing an action plan to deal with those issues
  - Reducing risk of being readmitted to the hospital
  - Assist in preparation for Transplant



For questions regarding BCBSNM's Care Coordination services, call **877-232-5518**

Health Risk Assessment (HRA)

The HRA is a standardized health screening that evaluates the health risks and allows for identification of the member's current health needs. If the member is agreeable to Care Coordination, a more comprehensive assessment is completed by the care coordinator and at that time the member's level of care is established.

The HRA may be conducted via telephone or in person.

Members who are not determined to meet the moderate or high level of care, are reviewed through quarterly claims mining. If, at that time, the member has or had a change in health status, they are assigned to a care coordinator and a Comprehensive Needs Assessment (CNA) is attempted.

Comprehensive Needs Assessment

- The CNA is a face-to-face assessment performed in the home* to identify areas of need and to help develop a care plan to address individualized needs.
  - Includes the member and several team members such as providers, school representatives, homemakers, family members and others who are part of the member's life
  - Can be performed outside of the home if HSD has granted an exception
- A new CNA will be attempted **biannually for high-risk members, annually for moderate-risk members** and at any time if there is a change in the member's health condition.
- PCPs and members will have a copy of the care plan.

*The CNA may be conducted outside of the member's primary residence if the member is homeless, or in a transition home; part of the jail-involved population preparing for release; or is in a Health Home or a Full Delegation Model.

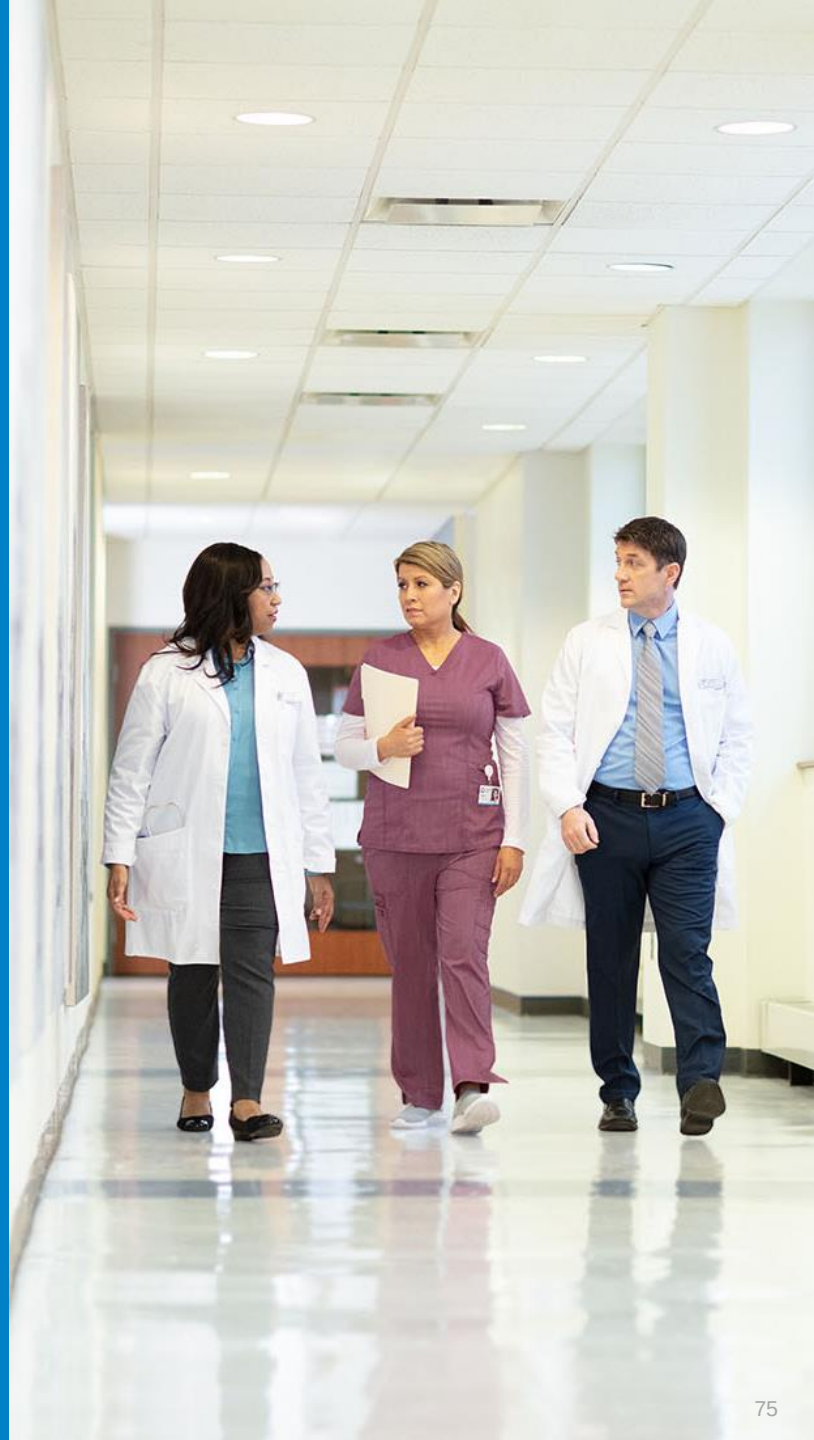
BCBSNM Supports an Integrated Care Approach

BCBSNM offers a seamless program for our Medicaid members to help meet their health care needs across the full array of Medicaid Covered Services:

- Acute and long-term care
- Behavioral health care
- Home and community-based services – a member must meet Nursing Facility Level of Care criteria to be eligible for home and community-based services

Members will have the opportunity for all Covered Services and Value-Added Services to be delivered in an integrated manner:

- Using a person-centered approach
- Developing personalized plans
- Furnishing appropriate access to Medicaid covered services



BCBSNM Teams to Support Our Members

Dedicated Care Coordination Teams to Support

- Special Beginnings (High-Risk Pregnancies)
- Children in State Custody
- Dual Special Needs Members
- Refugees
- Behavioral Health
- Members in Nursing Facilities
- Medically Fragile Members in collaboration with UNMH
- Members with Developmental Disabilities
- Justice (Incarcerated Members)
- Transitions of Care
- Comprehensive Addiction and Recovery Act-Drug Exposed Infants

Specialized Programs

- Complex Care Coordination Program
- Disease Management Program
  - Focusing on adult diabetes and pediatric asthma
- Brain Injury Program
- Emergency Room Reduction Program

Community Health Worker/ Peer Support Specialists

- Identify mental health and substance use resources
- Identify resources for housing for low-income and homeless
- Identify resources for meals, wood for wood stoves in the winter, water for those without running water
- Multiple community resources for heating, electricity, etc.
- Decrease emergency room utilization by linking members up with providers for care

Paramedicine Team

- Our team works with an independent ambulance provider that goes to the member's home following certain
  hospital discharges

Children in State Custody

- BCBSNM has a team of High Needs Care Coordinators
- High Needs Care Coordinators receive specific training for members involved in Children, Youth and Families (CYFD) juvenile justice services, protective services, behavioral health services and caretakers.
  - Children in State Custody (CISC)
  - Children in the Juvenile Justice System
  - Behavioral Health Services
- Coordinate discharge planning from hospitals and institutions (e.g. Nursing Facilities, Jails/Prisons, Juvenile Detention Centers, RTCs)
- High Needs Care Coordinators work closely with CYFD to identify children who may be high-risk, experiences traumatic events, engaging in delinquent behavior, or signs of SED or SMI.
- BCBSNM Members who are identified as CISC are required to have a comprehensive well child checkup within 30 days of coming into state custody.

Assessments to Improve Delivery Systems

There are many evidence-based quick assessments that BCBSNM utilizes. Here are some examples.

Assessments

- Health Risk Assessment
- Comprehensive Needs Assessment
- Monitor claims to identify members who might have high needs

Examples of other types of assessments and resources providers can utilize in their practice:

- **The Patient Health Questionnaire (PHQ)-9** is a nine-question, self-reported assessment that is easy to use and quickly scored. It is used to assess for major depressive disorder.
- **General Anxiety Disorder (GAD)-7** is used to screen for anxiety, social phobias, post traumatic stress disorder and panic. Like the PHQ-9, it is a self-reported assessment with seven quick questions. It also is quickly scored to determine if a referral to treatment is needed.
- **SAMHSA (Substance Abuse and Mental Health Services Administration)** offers numerous tools to assist providers in finding treatment, resources and assessment for members. SAMHSA.gov has different evidence-based screening tools to help quickly screen for substance use needs, including NIIDA-Modified ASSIST, S2BI, Brief Screener for Alcohol, Tobacco and other drugs.

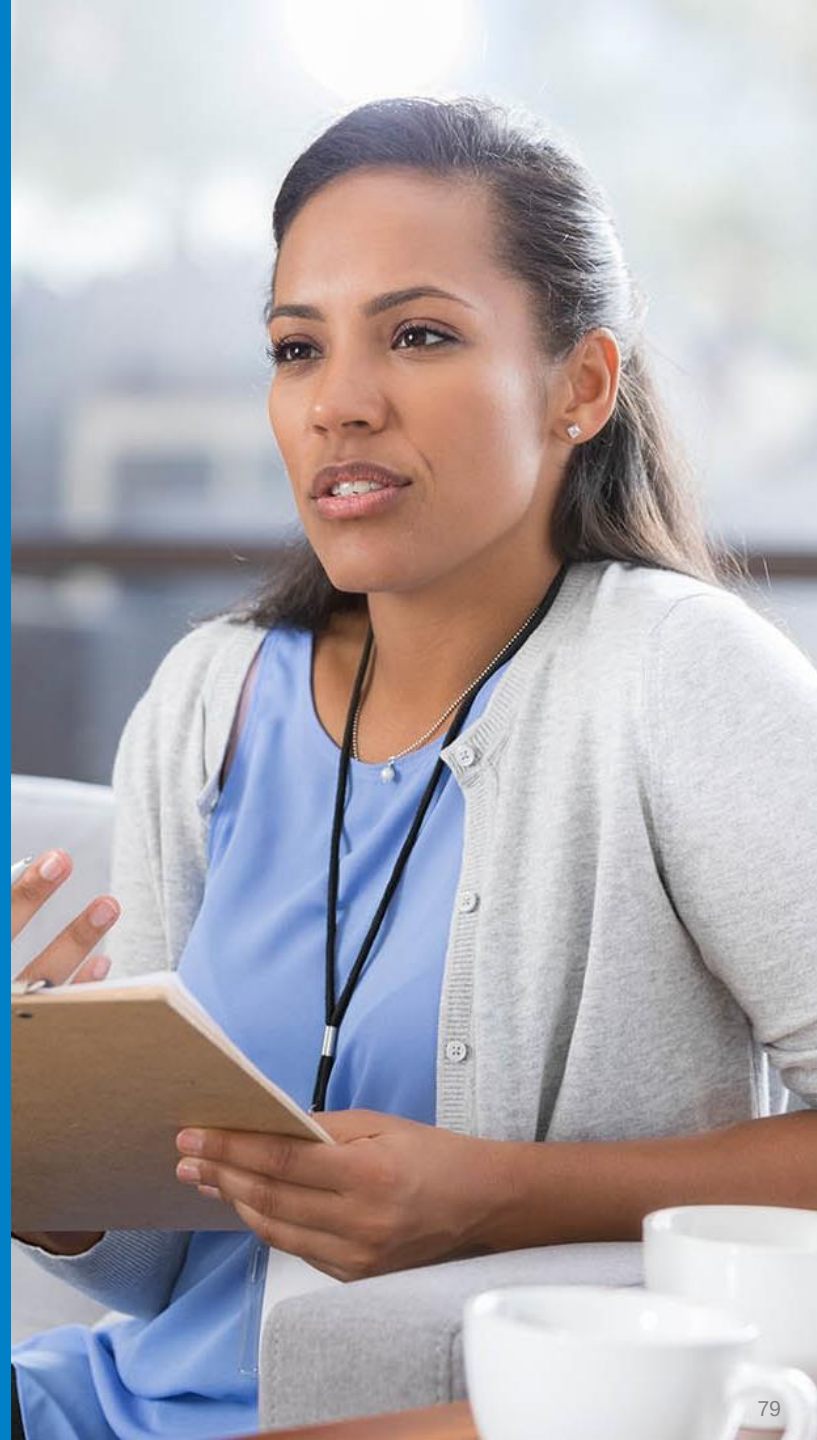
BCBSNM Supports the Improvement of Delivery Systems

Treatment/Service Plans

Some patients have substance use and/or mental health comorbidities, but without screening for them when indicated, they may be overlooked. There are evidence-based assessments that providers can utilize to efficiently assess a member's mental health or substance use needs. Those needs may include a referral for services from other providers. If a member's physical and mental health needs are addressed, their overall health is more likely to improve.

Discharge Planning

When indicated, BCBSNM staff collaborate with the facility for discharge planning (i.e., transition to a lower level of care when treatment plan goals are met and reintegration into the community is appropriate). A comprehensive discharge plan typically includes transitional planning, including an outpatient appointment with a PCP, psychiatrist or other specialist. This also includes assessing the need for DME, medications and resources when discharged home from an acute care or nursing facility. Attempts are made to schedule an appointment for within 7 days of discharge.



BCBSNM Supports the Improvement of Delivery Systems (cont.)

Models of Care (Member Centered/Trauma Informed)

BCBSNM makes available certain care model(s) (i.e., Clinical Guidelines) that have been designed so providers may better manage the care of the Blue Cross Community Centennial population (including DSNP), focusing on known service utilization patterns.

Behavioral Health Level of Care Guidelines

BCBSNM offers many Clinical Resources on our provider website at bcbsnm.com/provider/. These resources detail information on our Behavioral Health Care Management Program and Behavioral Health Level of Care Guidelines and resources. These programs help BCBSNM clinical staff identify members who could benefit from co-management earlier, and may result in:

- Improved outcomes
- Enhanced continuity of care
- Greater clinical efficiencies
- Reduced costs over time

Care Coordinators Work in Tandem with Providers

Care Coordinators:

- help connect members with providers to meet their health care needs to help improve quality of care
- conduct a Comprehensive Needs Assessment for all members in Care Coordination
- develop care plans
- educate members to better manage their conditions
- help build continuity of care
- may be part of a member's multidisciplinary care team
- receive alerts when their members are hospitalized to help with coordinating discharge planning and timely follow-up

Cultural and Linguistic Competency

Native American Care Coordinators

- Native American care coordinators are available upon request.
- If a Native American member requests a Native American care coordinator and one is not available, a community health worker will be present for all in-person meetings with the member and a non-Native American care coordinator.
- Blue Cross Community Centennial facilitates a language translation service called “Language Line.” The provider's staff will need to contact Member Services and request this service at **866-689-1523**.

Cultural and Linguistic Services – Health Literacy

The Care Environment

- Create a welcoming setting
- Make sure signs are understandable
- Give patients help with paperwork
- Watch for clues that a patient may need help
- Make your environment accessible

Providing Culturally Competent Care

- Have trained bilingual/bicultural staff and interpreters available
- Communicate in ways that can be easily understood by different audiences
- Provide equal access to services for all groups
- Weave knowledge of patient's culture and community into policy and practice
- Provide print materials in the languages of the community

Clear Communication

Using AIDET in a Health Literate Care Environment

- **A – Acknowledge**. Welcome the patient by name. This helps patients feel confident that you know and care about them and understand why they are there.
- **I – Introduce**. Introduce yourself by position or role in terms people understand. This creates confidence you are the right person for the job. And they know who to follow up with, if needed.
- **D – Duration**. Tell the patient how long the visit will take. Patients want to know how long they will be at the office or how long it will be until they get answers. When you respect a person's time, they become less anxious and can concentrate on what you are saying.
- **E – Explanation**. Use plain language to explain the need-to-know information about what is going to happen. Using plain language allows the person to understand the exam/procedure, how it will feel and what it is for. This allows time for questions before things progress. This is a time to use **teach-back** if needed.
- **T – Thank you**. Thank the patient for allowing you to care for them. Include an open-ended question regarding follow-up or other issues. Use teach-back one last time, if needed. People have choices. Let them know you appreciate their confidence and trust.

Annual Cultural Competency Training Requirement

- Annual Cultural Competency Training is required by the New Mexico Human Services Department for all providers contracted within Blue Cross Community Centennial.
- The training is available on our BCBSNM provider website, along with the Cultural Competency Training Attestation.

Cultural Competency Resources

Always Use Teach-back! Toolkit:
teachbacktraining.org/

Building Health Literate Organizations: A Guidebook to Achieving Organizational Change:
unitypoint.org/health-literacy-guidebook.aspx

Health Literacy Universal Precautions Toolkit – Agency for Healthcare Research and Quality Publication No. 10-0046-EF:
ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

Clear Health Communication Tools and Resources:
hsl.lib.unc.edu/health-literacy/communication-tools

Angela Gonzales, MA, BCBSNM Community Health Educator:
505-816-3022, angela_gonzales@bcbsnm.com

Fraud, Waste and Abuse

Fraud, Waste and Abuse

Reporting Fraud, Waste and Abuse:

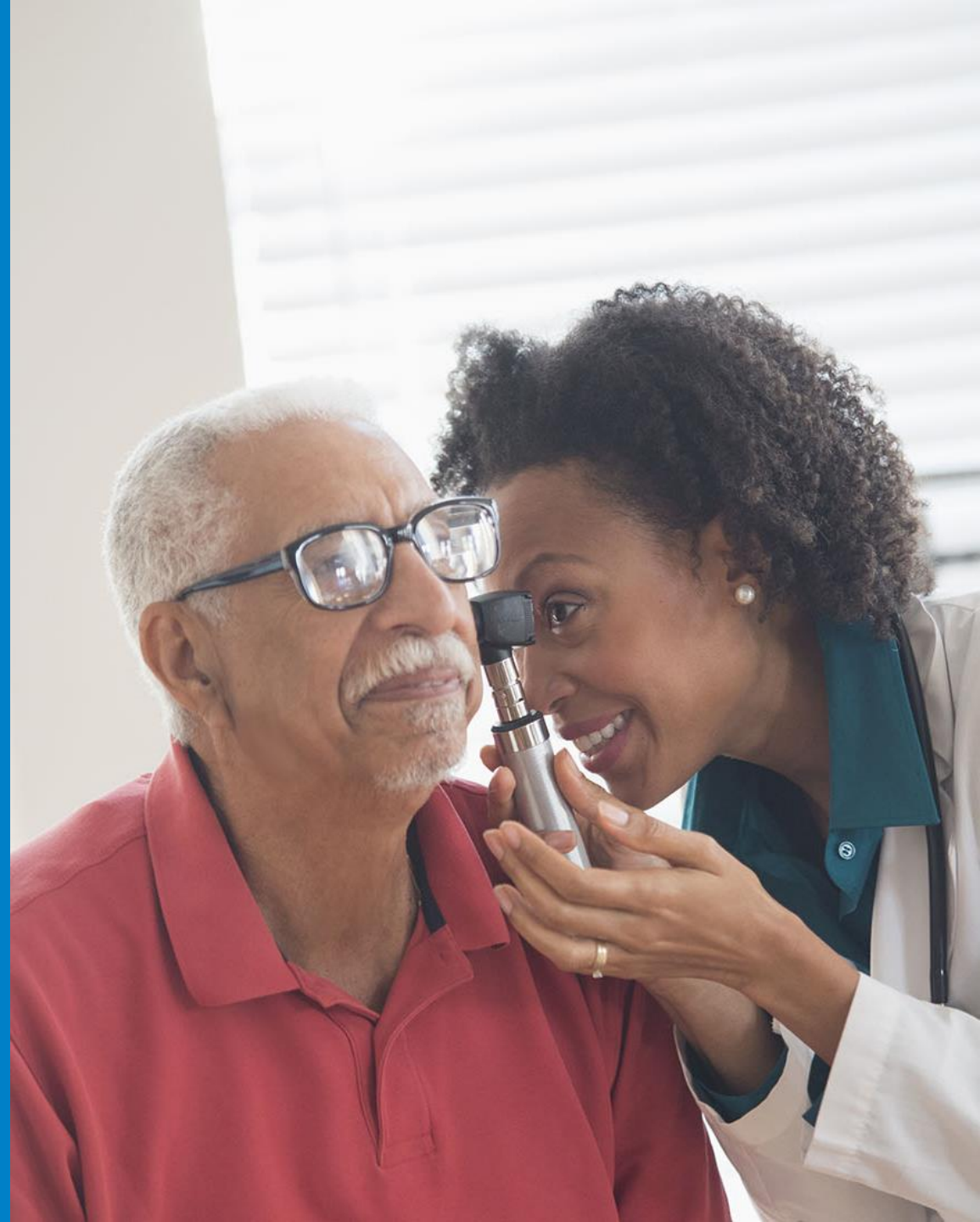
- Suspected fraud, waste and abuse should be reported to the BCBSNM Special Investigations Department (SID) by health care providers, subcontractors, vendors, members and other departments
  - **Fraud:** An intentional deception or misrepresentation by a person or an entity with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person
  - **Waste/Abuse:** Inappropriate utilization of services and misuse of resources; typically is not a criminal or intentional act
- SID toll-free Fraud Hotline: **800-543-0867**
  - Staffed and operational 24 hours a day, seven days a week, or
  - Report online at incidentform.com/BCBSFraudHotline.jsp

High-Volume Providers

High-Volume Providers

High-volume specialists are identified by an annual high-volume claims report which reflects the number of claims filed. High-volume specialists will include a minimum of three specialties in addition to mandatory inclusion of Obstetrics/Gynecology. Specialties analyzed can include, but are not limited to: Orthopedics (including Orthopedic Surgery), Rheumatology, Allergy/Immunology, Cardiovascular Disease and Ear-Nose-Throat (Otolaryngology). Other specialties may be identified based on the sub-populations, specific products/product lines or geographies.

High-impact specialists are identified by an annual claims report which reflects dollars paid. High-impact specialists will include any specialties determined as high-impact, but not already captured by high-volume analysis or other mandatory inclusion. High-impact specialists will include, at a minimum, the specialty of Oncology.



BlueCross BlueShield of New Mexico

Long Term Services & Supports

Blue Cross Community Centennial℠ • Provider Training • 2023

Such services are funded in part with the State of New Mexico. The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, provider network, and/or copayments/coinsurance are subject to change. Blue Cross and Blue Shield of New Mexico complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

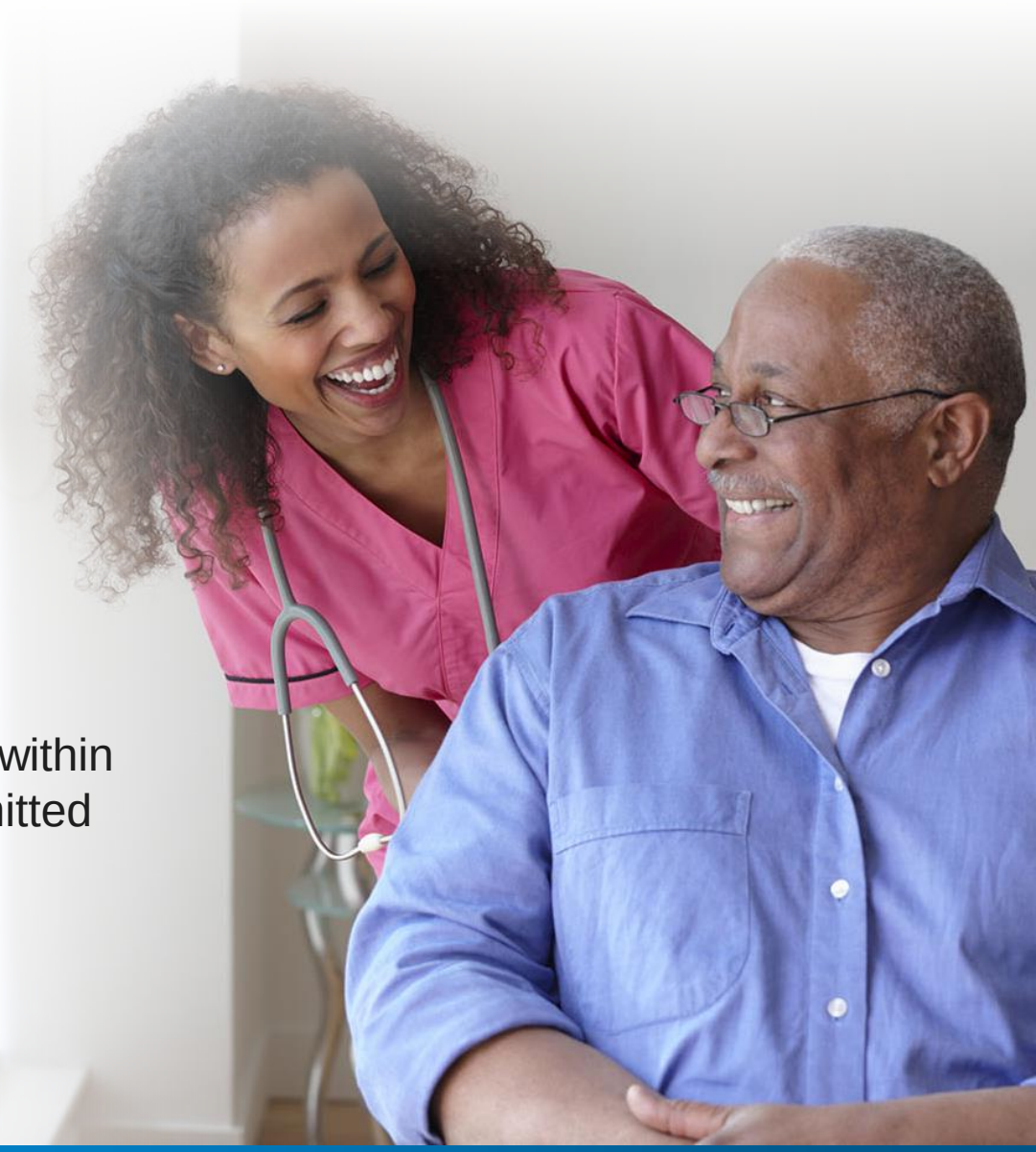
Nursing Facility (NF) Admissions and Discharges

Nursing facilities are required to notify Blue Cross and Blue Shield of New Mexico (BCBSNM) within 24 hours of a member's:

- Admission or request for admission including short-term stays
- Discharge:
  - Notify UM within 24 hours of the discharge
  - Facilities should notify their assigned Nursing Facility Care Coordinator or Reintegration Specialist as soon as possible to start the process of a safe reintegration
  - Has left Against Medical Advice
  - Hospital and/or Emergency Room encounters
  - Death
- Pending discharge
- Please call **877-232-5518**

Nursing Facility Level of Care (NFLOC) packets should be faxed within 30 days of admission and 60 days **prior** to expiration. If not submitted in a timely manner, it will affect the member's Medicaid eligibility.
Note: NFLOC should not be submitted for short-term stays.

- Long Term Care (LTC): 505-816-2093
- Clinical documentation: 505-816-3854



Important Reminders to Nursing Facilities

Initial Determinations

- All Services must be medically necessary
- Please refer to the Managed Care Policy Manual regarding procedures for prior approval

Redeterminations

- Medical documentation must be received by BCBSNM at least 60 calendar days prior to the start date of the new certification period for Low Nursing Facility (LNF) and 30 calendar days for High Nursing Facility (HNF)

Retroactive Medicaid Eligibility

- Written requests for prior approval based on resident's financial eligibility must be reviewed within 30 calendar days of the date of the eligibility determination

NFLOC Packet Components

Preadmission Screening and Resident Review

NFLOC Notification Form

- All requests for prior approval will be submitted on the NFLOC Notification Form
- Please document the type of review being requested at the top of the NFLOC Notification Form:
  - Initial
  - Continued Stay
  - Medicaid Pending
  - Transfer
  - Readmit
  - Reconsideration
- All other required fields must be completed

NFLOC Packet Components (cont.)

Minimum Data Set (MDS)

- An MDS and other appropriate documentation must be completed for each resident for every situation requiring prior approval
- All locator fields must be clearly marked on the MDS
- When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process
- Appropriate documentation must accompany the MDS including a valid order and must:
  - **be signed** by a physician, nurse practitioner, clinical nurse specialist or physician assistant;
  - **be dated**; and
  - **indicate the Level of Care (LOC)** – either high NF (HNF) or low NF (LNF)

Please refer to the **New Mexico Medicaid Nursing Facility (NF) Level of Care (LOC) Criteria and Instructions**.

Procedure for Transfers Between Nursing Facilities

The receiving NF must notify BCBSNM by telephone that a transfer to its NF is to occur and the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid.

- If there are **more than** 30 calendar days on the resident's current authorization, BCBSNM will fax the receiving NF the completed notification form which will include the prior authorization and date span.
- If there are **less than** 30 calendar days remaining on the current authorization, the receiving NF will request a continued stay on the notification form. BCBSNM will make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay.
- Please write "TRANSFER" in the type of request box on the notification form.

The NF receiving the resident will obtain the status of resident's reserve bed days from BCBSNM through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.

Agency-Based Community Benefit (ABCB) Covered Services

- Adult Day Health
- Assisted Living
- Behavior Support Consultation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Personal Care Services – Consumer Directed
- Personal Care Services – Consumer Delegated
- Private Duty Nursing for Adults
- Nursing Respite
- Respite (hourly and per diem)
- Skilled Maintenance Therapy Services
  - Occupational Therapy for Adults
  - Physical Therapy for Adults
  - Speech Therapy for Adults

Self-Directed Community Benefit (SDCB) Covered Services

- Behavior Support Consultation
- Customized Community Supports
- Emergency Response
- Employment Supports
- Environmental Modifications
- Home Health Aide
- Nutritional Counseling
- Private Duty Nursing
- Related Goods
- Respite
- Respite RN
- Self-Directed Personal Care
- Skilled Maintenance Therapy Services for Adults
- Specialized Therapies
- Start-up Goods
- Transportation (non-medical)

Self-Directed Community Benefit

SDCB Coverage Limitations	
Environmental Modifications	$6,000 every 5 years
Related Goods	$2,000 every year
Respite	300 hours per care plan year
Respite RN	300 hours per care plan year
Specialized Therapies	$2,000 per year
Start-up Goods	One-time coverage up to $2,000
Non-Medical Transportation	$1,000 per year

Home and Community-Based Services (HCBS) Settings Rule Overview

- The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS requirements on January 16, 2014 with an effective date of March 17, 2023
- Focused on improving available HCBS programs and overall quality
- Compliance with this Rule impacts state reimbursement from the Federal Government
- As a first step towards determining the compliance of New Mexico's HCBS provider settings, all selected Centennial Care providers were required to complete an online survey

<u>Services impacted by the Final Rule Include:</u>

Employment Supports (non-residential service)

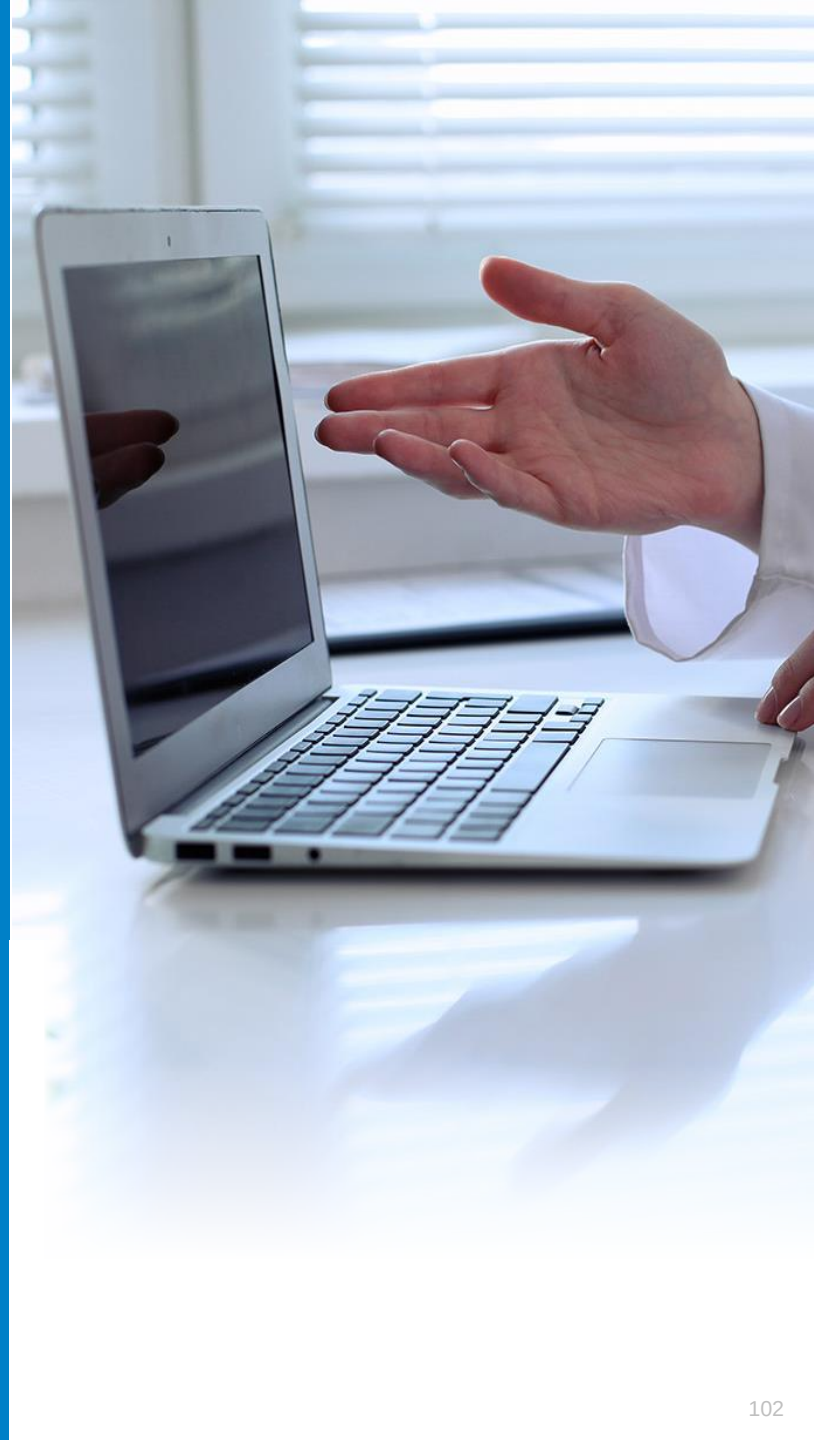
Adult Day Health (non-residential service)

Assisted Living (residential service)

HCBS Settings Rule Details

The Home and Community-Based settings must:

- Support individuals access to the greater community
- Provide opportunities for individuals to participate in individual and group outings (shopping, church, appointments)
- Provide the ability for individuals to seek employment
- Support individuals to receive the same degree of access to services in the community as those not living in a HCBS setting
- Allow individuals control over the scheduling of daily activities
- Allow visitors at any time approved by the individuals and access to private areas for conversation
- Must allow individuals to come and go as they please
- Provide access to transportation
- Compliance with all applicable rules and regulations.



HCBS Final Settings Rule Annual Attestation/Screening Tool and Audit

MCOs will train providers annually on the HCBS Final Settings Rule Requirements.

Providers will be required to complete an annual Attestation & Screening Tool.

MCOs will conduct annual on-site audits/screenings to initiate remediation process as applicable.

Care Coordination assessments and touchpoints will allow MCOs to gather valuable information on the HCBS Final Settings Rule Requirements.

Agency Based Community Benefit (ABCB) Annual Audits

MCOs will audit ABCB providers on an annual basis to determine compliance with the requirements set forth for all ABCB's as defined in the Centennial Care Managed Care Policy Manual and the New Mexico Administrative Code (NMAC).

All elements of the audit are included under Section 8 of the Managed Care Policy Manual and Section 8.320.2.18.C NMAC.

This audit includes all ABCB Provider Types

Agency Based Community Benefit (ABCB) Annual Audits

Providers will receive a formal documentation request along with an audit tool with the details and a timeline to return the requested documents. Providers are to submit the requested documentation within fourteen (14) calendar days from the date of the letter.

Providers will receive a non-compliance letter if they fail to comply with the audit request. The goal is to help providers come into compliance.

Upon completion of the audit, providers will receive a Final Results letter which will score providers as "compliant" or "non-compliant".

Important Reminders to HCBS Providers

Information you provide helps BCBSNM and other providers to better serve members. Please remember to:

- **Complete and submit the Critical Incident Report when a member has an adverse event**
- **Assist members with contacting BCBSNM Member Services and/or their care coordinator when they move or change phone numbers**
- **Provide the Individualized Plan of Care when requested**
- **Notify the member's care coordinator if you become aware of any issues that may affect a member's health and safety**

Electronic Visit Verification (EVV)

EVV was established to ensure that members are receiving authorized personal care services (PCS) on the day and time approved.

- EVV for the Agency-Based Community Benefit population was implemented statewide in 2016.
- EVV implementation for Early and Periodic Screening, Diagnostic and Treatment – Personal Care Services (EPSDT PCS) on January 1, 2020, and for the Self-Directed Community Benefit population on January 1, 2021.
- EVV implementation for Home Health and Respite will go live on January 1, 2024. The EVV requirements are federally mandated by Section 12006 of the 21st Century Cures Act.

Additional Notes on EVV

Manually Entered Web Claims

In April 2018, a new enhancement deployed within the Authenticare system required the Centennial Care Managed Care Organizations to review all manually entered web claims. This enhancement will also require Personal Care Service agencies to collect and maintain documentation for every manually entered transaction and use of an exception.

Providers are required to provide detailed notes on each manually entered web claim.
If BCBSNM has any questions regarding a web-based claim, either the assigned BCBSNM EVV contact, or a provider representative will request you to supply supporting documentation further justifying the reason for the manual entry.

Worker Relationships

You are required to identify the worker relationship (spouse, parent, other, etc.) in Authenticare for each member.

Authenticare User Guides and Trainings

When logged into the Authenticare system, the agency can find helpful resources under the Custom Links tab on the main screen. These include the Authenticare User Manual, Provider Documents and the SDCB Training.

EVV Access Options

Multiple Authenticare® Access Options Available

- Option #1: Member's home phone/landline or cell phone – If allowed by the member, caregivers will use their member's home phone/landline or cell phone to call into the AuthentiCare Interactive Voice Response (IVR) system; or
- Option #2: Caregiver's Mobile Device (smartphone or tablet) with Stipend – Each managed care organization (MCO) will provide a stipend to the provider agency to create an incentive for caregivers to utilize their personal mobile device (smartphone or tablet) and existing data plan when using the AuthentiCare mobile application for data transfer. The entire stipend must be paid to the caregiver and the agency may not retain any of it. All stipend payments made by the MCOs are inclusive of gross receipts tax (GRT); or
- Option #3: Tablets – The option to order a BCBSNM-owned WiFi-enabled tablet for those caregivers who do not have access to a personal mobile device (smartphone or tablet) or a member's home phone/landline or cell phone. Provider agencies can place orders through mobilityexchange.us. Please ensure all orders include a valid BCBSNM member ID number (including prefix YIF) or Medicaid ID.
- Additional terms and conditions may apply.

Managed Care Policy Manual

The purpose for the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by the New Mexico Human Services Division (HSD) for the administration of the Medicaid managed care program and to provide direction to the managed care organizations (MCOs) and other entities providing services under managed care.

This Manual should be used as a reference and a general guide. It is a resource for interpreting the Medicaid Managed Care Services Agreement (the Agreement) and New Mexico Administrative Code (NMAC) rules pertaining to managed care.

- ✓ Section 6: Nursing Facilities (NF)
- ✓ Section 7: Community Benefits
- ✓ Section 8 : Agency Based Community Benefits (ABCB)
- ✓ Section 9 : Self Directed Community Benefits (SDCB)

New Mexico Administrative Code (NMAC)

The New Mexico Administrative Code (NMAC) is the official collection of current rules (regulations) written and filed by state agencies to clarify and interpret laws passed by the legislature.

Helpful Sections for Providers:

Chapter 302 – Medicaid General

Chapter 308 – Managed Care Program

– NMAC 8.308.12 Community Benefits

Chapter 312 – Long Term Care Services / Nursing Services

Chapter 320 – Early and Periodic Screening, Diagnosis & Treatment Services (EPSDT)

BCBSNM LTC Key Contacts

BCBSNM **Long Term Care Network Representatives** are organized by geographical region.

- For the most up to date list of LTC Provider Representative assignments, please visit https://www.bcbsnm.com/provider/contact-us

David Hall
Northwest Region
Southwest Region Alpha N-Z
Bernalillo County Alpha F-R
David_Hall@bcbsnm.com
Office: 505-962-7215

Jessica Maito
Eastern Region
Southwest Region Alpha A-M
Bernalillo County Alpha A-E and S-Z
Value Based Providers (LTC)
Jessica_Maito@bcbsnm.com
Office: 505-816-5214

Electronic Visit Verification
Christy Gray
Christina_Gray@bcbsnm.com
Office: 505-816-2237

Authorizations
PCS@bcbsnm.com

Reoccurring Meetings/Trainings

BCBSNM holds regular provider meetings with This allows providers to collaborate with BCBSNM and identify trends and issues that need resolution. It also allows providers an opportunity to request specialized trainings.

Some of these meetings are in partnership with the other MCOs and/or HSD.

- Personal Care Service (PCS) Provider Meetings
- Assisted Living Facility (ALF) Provider Meetings
- Nursing Facility (NF) Provider Meetings

If you are interested in attending or need to update your agency's contact information, please reach out to your assigned provider representative.

Home and Community Based Service (HCBS) Final Settings Rule Training

Two Training options to select from,
March 14th, 10:00-11:30 or
March 17th, 9:00-10:30

Agenda

Overview of the HCBS Final Rule

New Mexico's HCBS Transition Plan

- Annual Provider Assessment
- Onsite Reviews
  - Process Prior to Review
  - Overview of Audit Tools
    - Questions and Probes
  - Additional Tips
  - Follow-Up after Assessment

HCBS Final Rule Partnerships

- Managed Care Organizations
- Department of Health

HCBS Final Setting Rule Overview

- The Centers for Medicare and Medicaid Services (CMS) issued a Final Rule for HCBS requirements on January 16, 2014 with an effective date of March 17, 2023

- Focused on improving available HCBS programs and overall quality

- Compliance with this Rule impacts state reimbursement from the Federal Government

- As a first step towards determining the compliance of New Mexico's HCBS provider settings, all selected Centennial Care providers were required to complete an online survey

Final Rule Objectives

Enhanced Quality in HCBS Programs	Added Protection of Individuals receiving these services	Assurance that individuals receiving services and supports through Medicaid HCBS programs have full access to the benefits of Community Living	Access to care in the most Integrated setting	Emphasizes Personal Autonomy and Choice	Establishes more stringent rules for provider- owned or controlled residential settings

Agency Based Community Benefits

Services impacted by the Final Rule Include:

- Employment Supports (non-residential service)
- Adult Day Health (non-residential service)
- Assisted Living (residential service)

HCBS Specifics

- **Integration** in, and supports access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

- **Selection by the individual** from among all settings options that are identified and documented in the person-centered service plan and are based on the individual's needs and preferences;

- Ensure individual **rights of privacy, dignity and respect**, and freedom from coercion and restraint;

- **Optimize autonomy and independence** in making life choices;

- Facilitate **choice** regarding services and who provides them; and

- **Admission, Transfer, and Discharge Rights;** Requiring that a transfer or discharge be documented in the medical record and that specific information be exchanged with the receiving provider or facility when a resident is transferred.

What does this mean to you?

- Supports for individuals to access the greater community
- Opportunities for individuals to participate in individual and group outings (shopping, church, appointments)
- Ability for individuals to seek employment
- Support for individuals to receive the same degree of access to services in the community as those not living in a HCBS setting
- Individual control over the scheduling of daily activities
- Allowance of visitors at any time and access to private areas for conversation
- Ability of individuals to come and go as they please
- Access to transportation
- Individual access to their own funds when they want

Ensuring Compliance with the Final Rule

MCO Monitoring Activities

- Incorporate HCBS Final Rule training into MCO Provider Orientation
- Joint MCO Annual Provider Trainings to provide focused education of HCBS Final Rule requirements
- Inclusion of expectations in contracting requirements
- Annual Attestation & Screening Form completion
  - MCOs will review Screening Tools
  - Initiate remediation process as applicable
- Care Coordination assessments and touchpoints are a valuable means to gather information
  - Review of Person-Centered Plan
  - Interview of member via the standardized care coordination statewide tool
  - Internal MCO Care Coordination escalation process
- Appeals and Grievances

Onsite Validation Overview

As a follow-up to the provider surveys, providers are subject to an onsite validation review

EVALUATE

Review the physical environment and the delivery of services of the provider setting to ensure compliance with the HCBS Final Setting Rule

VALIDATE

Confirm the information received in the provider survey via an in-person assessment

Care Coordination Tool

Ongoing assessments and touchpoints

STAFF INTERACTIONS

Services are provided in a 'homelike' environment- promoting interactions between participants

CHOICE OF CARE

Participants have a choice in the way they receive care and actively involved in the decision-making process

FLEXIBILITY

There is not a regimented schedule- there is some degree of flexibility

Onsite Validation

Onsite Visit Overview

Pre-Assessment Activities

MCO role: Provider Network sends out a letter within 30 days of scheduling an on-site visit Provider role: Provider sends available time to conduct an on-site visit with the MCO

On-Site Visit

MCO Role: Provider Network conducts MCO Provider Settings Rule assessment MCO Role: Care Coordinator conducts Member settings Rule Assessment when conducting Comprehensive Needs Assessment and during ongoing Touchpoints

Post Assessment Review/Validation

MCO Role: MCO reviews findings and sends recommendations to the Provider

Remediation/Action Provider Role

Provider develops a plan to correct issues/concerns based on the MCO's findings. Celebrate Successes

Onsite Review: Overview of Tools

Residential Settings Tool

Assisted Living Facilities

- Choice of Residence
- Community Access and Integration
- Living Space
- Staff Interactions and Privacy
- Services

Non-Residential Settings Tool

Adult Day Health & Employment Supports

- Choice of Setting
- Community Access and Integration
- Setting Space
- Staff Interactions, Privacy and Choice

Onsite Reviews Overview of Tools

General Information Found Tool

-Reviewer name

-Date of review

-Programs in which the provider participants

-Services

    -For Providers-Services they delivery

    -For Members- Services they receive from the provider

-Services setting address

Onsite Tool

- Attestation/Screening Process occurs prior to on-site visit
- On-site Validation Tool

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ANNUAL CENTENNIAL CARE AGENCY BASED COMMUNITY BENEFIT PROVIDER ATTESTATION FORM CMS FINAL RULE FOR HCBS

Please read the following summary of the Centers for Medicare and Medicaid Services (CMS) Final Rule Requirements for Home and Community Based Services (HCBS) Providers.

Any residential or non-residential provider who offers agency-based community benefit services in a setting where individuals live and/or receive HCBS must comply with the provider setting requirements. A HCBS setting is provider-owned or controlled when the setting in which the individual resides is a specific physical place that is owned, co-owned, and/or operated by a provider of HCBS.

The CMS Final Rule requirements for residential and non-residential HCBS settings include:

1) **Integration in the Community**
Providers must ensure that settings are integrated in and support full access of individuals to the greater community including:
   - Providing opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; and
   - Ensuring that individuals receive services in the community, to the same degree of access as individuals not receiving HCBS.

2) **Comprehensive Person-Centered Care Planning**
Providers must ensure that the individual selects from among setting options including non-disability specific settings and options for a private unit in a residential setting. The provider setting must have person-centered service plans that document the options based on the individual's needs and preferences. For residential settings the person-centered plan must document resources available for room and board.

Screening and Attestation

Residential Providers

1. Are there set rules or set times for when individuals can have visitors?
2. If yes, please described details:
3. Are Resident's allowed to come and go as they please? For example: Can individuals participate in unscheduled community activities such as shopping, church, visit family/friend, when they want to?
   If no, please explain:
4. How do you ensure Resident's Health information is secure and Confidential?
5. What is your process for developing an individual Plan of Care? Please address the following areas in your response:
   - Does the resident/POA have input?
   - What happens if there is a change to the Plan of Care?

Onsite Review: Post Assessment

- Each review will conclude with a closing meeting:
  - A letter will be provided by the MCOs indicating the results of the review
  - Review identified issues and the allotted timeframe to remedy in alignment with an action plan
    - Additional information may be requested as part of the action plan
  - Answer any questions regarding the review process and provide support

Next Steps: Provider Assessment Results

The appropriate compliance bucket will be determined for each provider based upon the results of the assessment/surveys and on-site validation

CATEGORY 1	CATEGORY 2	CATEGORY 3	CATEGORY 4
Compliant	Compliant with Remediation	Presumptively Institutional	Institutional

Next Steps: Provider Assessment Results

CATEGORY 1 – Compliant

- Provider scores 100% on the provider assessment and has no remediation findings through the on-site or desk validation process
- Providers initially deemed compliant will continue to be monitored by the MCOs for ongoing compliance

CATEGORY 2 – Compliant with Remediation

- Provider scores less that 100% on the provider assessment and has some remediation findings through the on-site or desk validation processes
- Providers will be given an opportunity to remediate the issues identified. Once these are remediated, providers will move into ongoing monitoring

Next Steps: Provider Assessment Results Continued

CATEGORY 3 – Presumptively Institutional

- In the on-site assessment, observation of any of the following characteristics will result in a setting being characterized as presumptively institutional:
  - Does not provide individuals with disabilities multiple types of on-site services/activities
  - Limits integration with the broader community
  - Uses interventions or restrictions used in institutional settings or deemed unacceptable in institutional settings

- Settings in this category will be subject to heightened scrutiny review

CATEGORY 4 – Institutional- Seek HSD's Direction

It is unlikely that a setting will be immediately deemed institutional as a result of this process

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