BlueCross BlueShield of New Mexico

Provider Food Programs:

Community Benefit
Medically Tailored Home Delivered Meals

Disclaimers

ConduentHR Services, LLC (“Conduent”) and The Bank of New York Mellon (“BNY Mellon”) are affiliated companies that provide HSA/FSA/HRA administration services as BenefitWallet. Conduent is the administrator of the BenefitWallet HSA product. BNY Mellon is the custodian. The relationship between Blue Cross and Blue Shield of New Mexico, Conduent and BNY Mellon is that of independent contractors.

Conduent and BNY Mellon are separate companies that are solely responsible for administration of the health savings account associated with the BlueEdge HSA℠ and FSA plans. Please note that the HSA is a separate account established by the member in accordance with an agreement with an independent third-party bank over whom BCBSNM has no control or right of control.

HSA Bank is a division of Webster Bank, N.A. Member FDIC. HSA Bank is registered in the U.S. Patent and Trademark Office.

The relationship between BCBSNM and Conduent, BNY Mellon, Connect Your Care, Flexible Benefit Service Corporation and HSA Bank is that of independent contractors. These companies are independent companies that are solely responsible for administration of one or all of the HSA/FSA/HRA associated with the BlueEdge HSA and BlueEdge FSA plans.

What Are Medically Tailored Meals?

Community Benefit Home-Delivered Medically Tailored Meals **are fully prepared meals** designed by a registered dietitian nutritionist to meet the unique nutritional requirements of members with various health conditions.

This service is intended to support vulnerable **home-bound Community Benefit members,** is implemented under the 1115 waiver **and includes up to two home-delivered** medically tailored meals **per day.**

The intent of the meals program is to provide **cultural, religious and personally appropriate** home-delivered meals at no cost to the member.

What Are Medically Tailored Meals?

(Continued)

Providers must be able to deliver to the **member's residence** or other appropriate location, including last mile delivery, and track and report on service delivery, including unsuccessful deliveries.

The effective date for Agency-Based Community Benefit Home-Delivered Medically Tailored Meals is **July 1, 2025.**

It's anticipated that Self-Directed Community Benefit Medically Tailored Meals **may be implemented in 2026.** The Health Care Authority will provide additional guidance to managed care organizations prior to the program implementation.

Covered Services and Limitations

- Community Benefit medically tailored home-delivered meals are provided on a regularly scheduled basis **for one or more days per week, or as specified in the comprehensive care plan**, in a noninstitutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Services are furnished consistent with the member's person-centered care plan.
- Meals provided as part of this service shall **not constitute** a "full nutritional regimen" (three meals per day).

Community Benefit Home-Delivered Medically Tailored Meals:

- **Are not provided** to Community Benefit members who reside in a licensed assisted living facility.
- **May not be provided** if the member already receives medically tailored full nutritional support from another program.
- **May be provided** to members who receive adult day health services**,** if medically tailored meals are not provided at the licensed ADH facility.

1 Provider Requirements

Agency Based Community Benefit Annual Audits

- As part of the annual audits, managed care organizations audit Community Benefit Medically Tailored Meals providers to determine compliance with the requirements as defined in the managed care policy manual.
- **Provider requirements are outlined in Letter of Direction #57 Community Benefit Medically Tailored Home Delivered Meals.**
- Providers will be audited during the onboarding/contracting process and annually thereafter to ensure that they meet provider requirements.
- During the annual audit, if a Community Benefit Medically Tailored Meals provider is contracted with multiple MCOs, they will only be audited by one of the participating MCOs.

Agency Based Community Benefit Annual Audits (Continued)

- The MCOs participate in an all-MCO workgroup to discuss audit progress and results, as necessary. MCOs will be assigned specific providers to ensure that all Agency-Based Community Benefit providers are audited annually.
- Providers will only be audited once per calendar year, even if the provider is contracted with more than one MCO.
- Providers will receive a formal documentation request along with the all-MCO audit tool with the details and a timeline to return the requested documents.
- Providers are to submit the requested documentation within **30 calendar days** from the date of the letter.
- Providers can request a technical assistance call if they have any questions regarding the audit.
- Upon completion of the audit, providers will receive a **final results letter,** which will score providers as “compliant” or “”non-compliant.”
- Providers who are nonresponsive or fail to comply with the audit will receive a **noncompliance letter.**
- Providers who do not comply with audit requirements may be sanctioned up to, and including, termination of their provider agreement by the MCO.

Provider Requirements for Community Benefit Medically Tailored Meals

- Must be enrolled in New Mexico Medicaid as **Provider Type 363** Community Benefit with a **specialty code 330**.
- Must have knowledge of principles, methods and procedures of the covered nutrition interventions meant to support an individual in obtaining food security and meeting their nutritional needs.
- Must be able to receive referrals from Turquoise Care MCOs. **Prior authorization is not required.**
- Must be able to deliver to the member's residence or other appropriate location, including last mile delivery, and track and report on service delivery, including unsuccessful deliveries.
- Must comply, during all stages of food service operation, with applicable federal, state and local regulations, codes and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety and welfare of individuals receiving Community Benefit Home-Delivered Medically Tailored Meals.

Provider Requirements for Community Benefit Medically Tailored Meals (Continued)

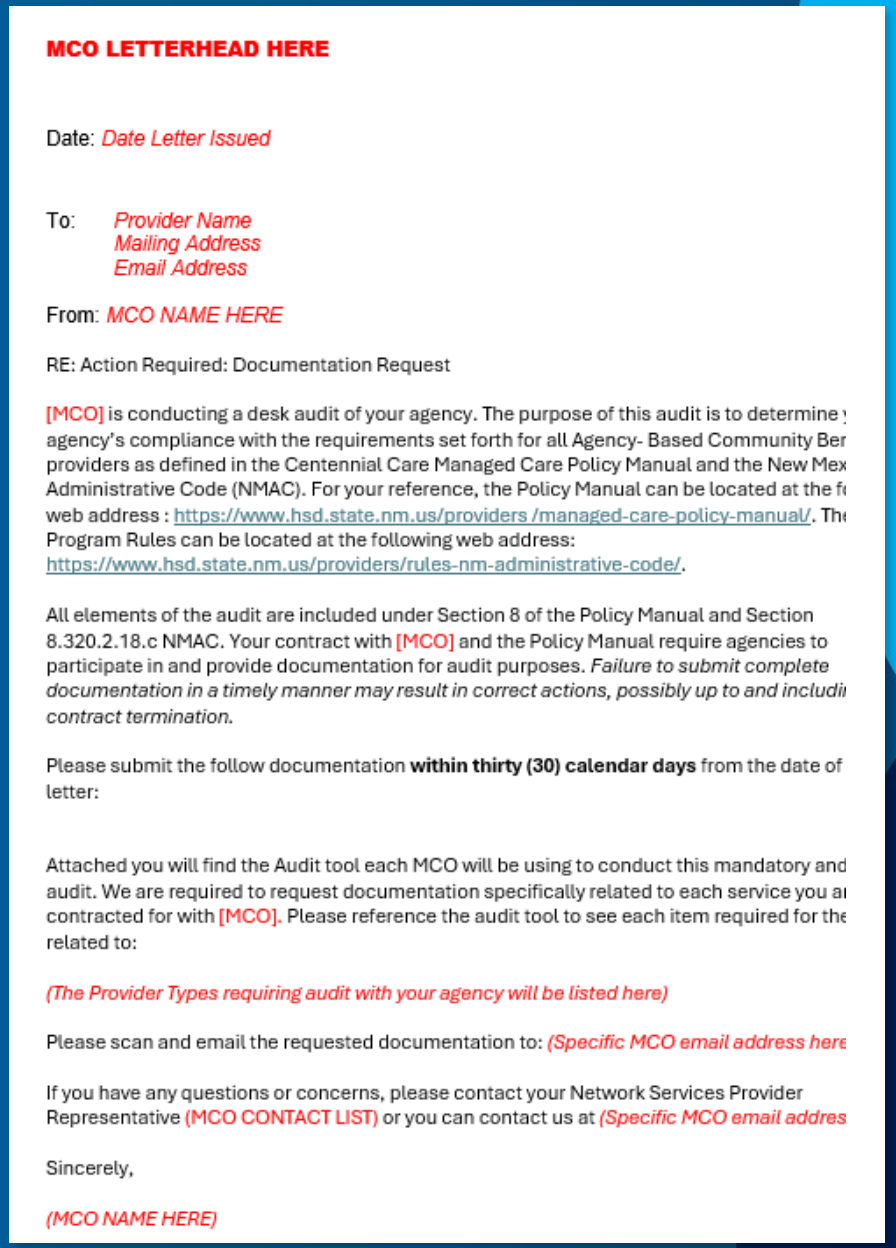
- Must follow best practice guidelines and industry standards for food safety. This includes meals remaining at safe temperatures, hot or cold, during transit and delivery.
- Must include a registered dietician or RDN or other comparable professional to develop the nutritional content of the meals.
- Must be able to customize meals to a member's cultural, religious and personal preferences.
- Must ensure that any employee or volunteer who delivers these meals to a member's home has passed a background check, or the provider must use a delivery service such as U.S. Mail.
- Must not solicit payment or donations from any Medicaid member or their families or representatives.
- The provider will survey or connect with members on regular intervals to ensure quality of food and address any concerns.

Initial Documentation Request

Your agency will receive a letter via mail and email to your administrative and email address on file with the MCO.

- The Agency-Based Community Benefit All-MCO Audit Tool will be included.
- Each Agency-Based Community Benefit provider type will have its own tab on the audit tool, identifying the required audit elements.
- If you are an agency providing multiple Agency-Based Community Benefit services, you will be required to complete an audit for each service.

Timeline: You will have **30 calendar days** from the date of the letter to submit the required audit documentation.



MCO LETTERHEAD HERE

Date: *Date Letter Issued*

To: *Provider Name*
Mailing Address
Email Address

From: *MCO NAME HERE*

RE: Action Required: Documentation Request

[MCO] is conducting a desk audit of your agency. The purpose of this audit is to determine y agency's compliance with the requirements set forth for all Agency- Based Community Ber providers as defined in the Centennial Care Managed Care Policy Manual and the New Mex Administrative Code (NMAC). For your reference, the Policy Manual can be located at the f web address : https://www.hsd.state.nm.us/providers /managed-care-policy-manual/. The Program Rules can be located at the following web address: https://www.hsd.state.nm.us/providers/rules-nm-administrative-code/.

All elements of the audit are included under Section 8 of the Policy Manual and Section 8.320.2.18.c NMAC. Your contract with [MCO] and the Policy Manual require agencies to participate in and provide documentation for audit purposes. *Failure to submit complete documentation in a timely manner may result in correct actions, possibly up to and includi contract termination.*

Please submit the follow documentation **within thirty (30) calendar days** from the date of letter:

Attached you will find the Audit tool each MCO will be using to conduct this mandatory and audit. We are required to request documentation specifically related to each service you a contracted for with [MCO]. Please reference the audit tool to see each item required for the related to:

(The Provider Types requiring audit with your agency will be listed here)

Please scan and email the requested documentation to: *(Specific MCO email address here*

If you have any questions or concerns, please contact your Network Services Provider Representative (MCO CONTACT LIST) or you can contact us at *(Specific MCO email addres*

Sincerely,

(MCO NAME HERE)

Annual Audit Submissions

1. Providers are to submit the required documentation to the assigned MCO identified on the initial documentation request letter.

2. If you are assigned to Blue Cross and Blue Shield of New Mexico, please email your submission.

3. You will be contacted by the assigned MCO if there are any questions or missing documentation.

3 Provider Resources

Managed Care Policy Manual and Medicaid Portal

The purpose for the Managed Care Policy Manual is to provide a reference for the policies established by Health Care Authority for the administration of the Medicaid managed care program and to provide direction to the MCOs and other entities providing service 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 rules pertaining to managed care.

The policy is available here.

- Section 07 - Community Benefits
- Section 08 - Agency Based Community Benefits
- Section 09 - Self Directed Community Benefits

New Mexico Medicaid Portal

- Providers can use the New Mexico Medicaid Portal to find information about policy and billing, claims submission, client eligibility, financial issues, Medicare, provider enrollment, third party liability, remittance advices and more.

Participating with Blue Cross and Blue Shield of New Mexico

Providers applying for network participation with BCBSNM are required to register with the HCA:

- Must register as a Managed Care-only provider, or as Fee-for-Service and Managed Care. Providers applying for network participation with BCBSNM are required to register with the HCA
- 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

- Visit YES New Mexico Medicaid Portal
- Email NM.Customers@hca.nm.gov
- Call 800-283-4465
- Text 505-370-7130

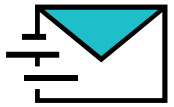
Provider Resources

- See our provider website for resources, trainings and information.
- Update your demographic information
- Review our Provider Reference Manual
- Access or request specialized training
- Review or sign up for our monthly *Blue Review*℠ newsletter
- Check the list of provider representative assignments. Provider representatives are organized by geographical region and provider type.

How to Submit Claims

Electronic submission

- **Payer ID MC721**
- For information on electronic filing of claims, contact Availity® Essentials at **800-282-4548**



Paper submission

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

Duplicate claims

- Verify claims receipt and adjudication with BCBSNM via Availity Essentials prior to resubmitting to prevent denials

Submit forms to:

- Claims: BCBSNM, PO Box 650712 Dallas, TX 75265-0712
- Appeals: BCBSNM, PO Box 660717 Dallas, TX 75266-0717

Billing and Reimbursement for Community Benefit Medically Tailored Meals

Procedure Code	Units	Reimbursement
S5170	1 meal = 1 unit (2 units max/day)	$8.00/meal

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

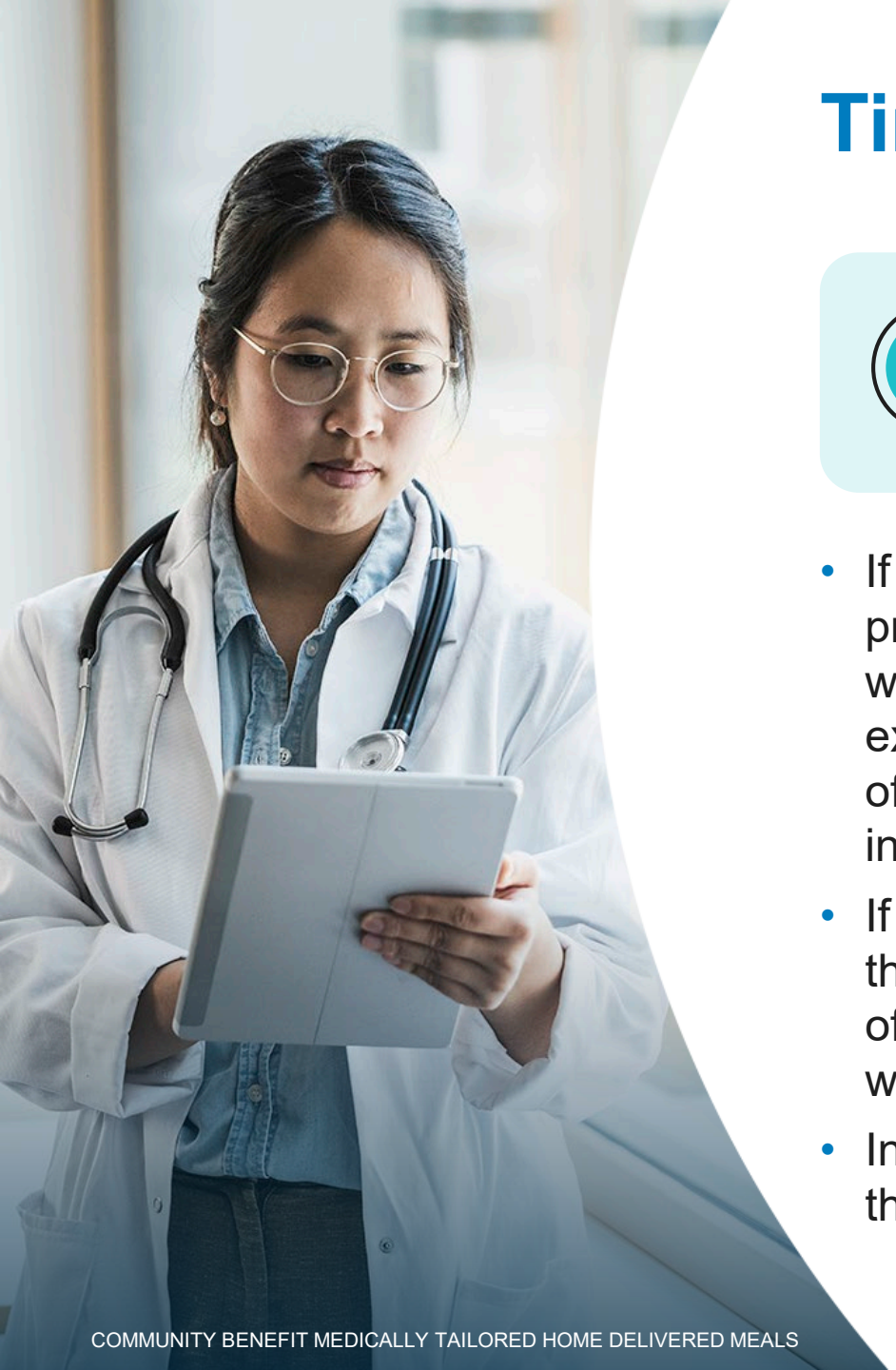
Participating Provider Information

- Provider's Tax Identification Number
- Provider NPI 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
- Current Procedural Terminology (CPT®) procedure codes
- NDC codes in accordance with Medicaid requirements
- Date(s) of service(s)
- Charge for each service

Reminder: Before submitting a claim, validate that all charges are listed, and all necessary information has been provided to avoid late charges and corrected claims.



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. 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.
- Indian/tribal/urban providers have up to two years from the date of the service to file claims.

BlueCross BlueShield of New Mexico

Thank you for joining our webinar!

Questions