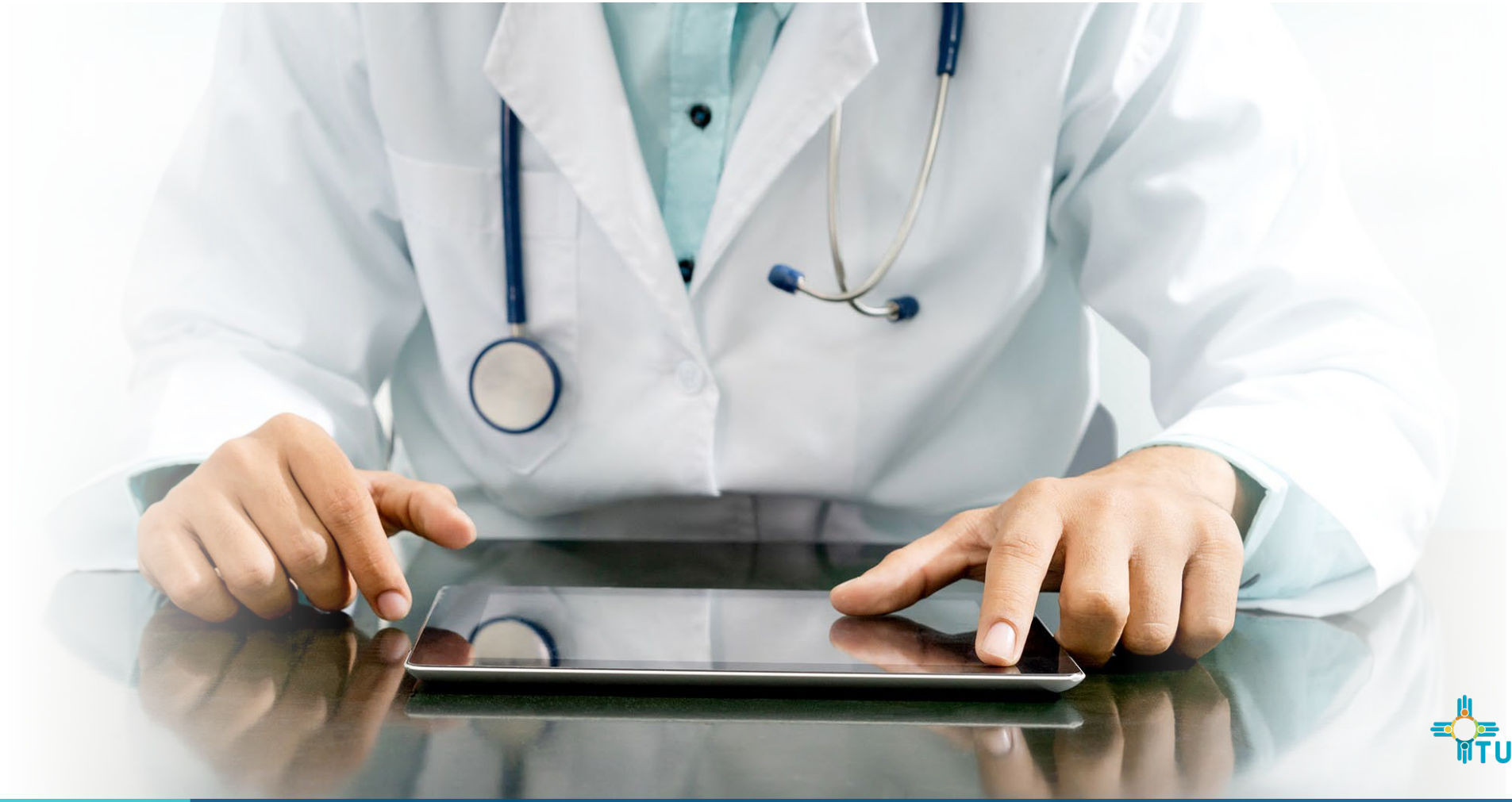


BlueCross BlueShield of New Mexico

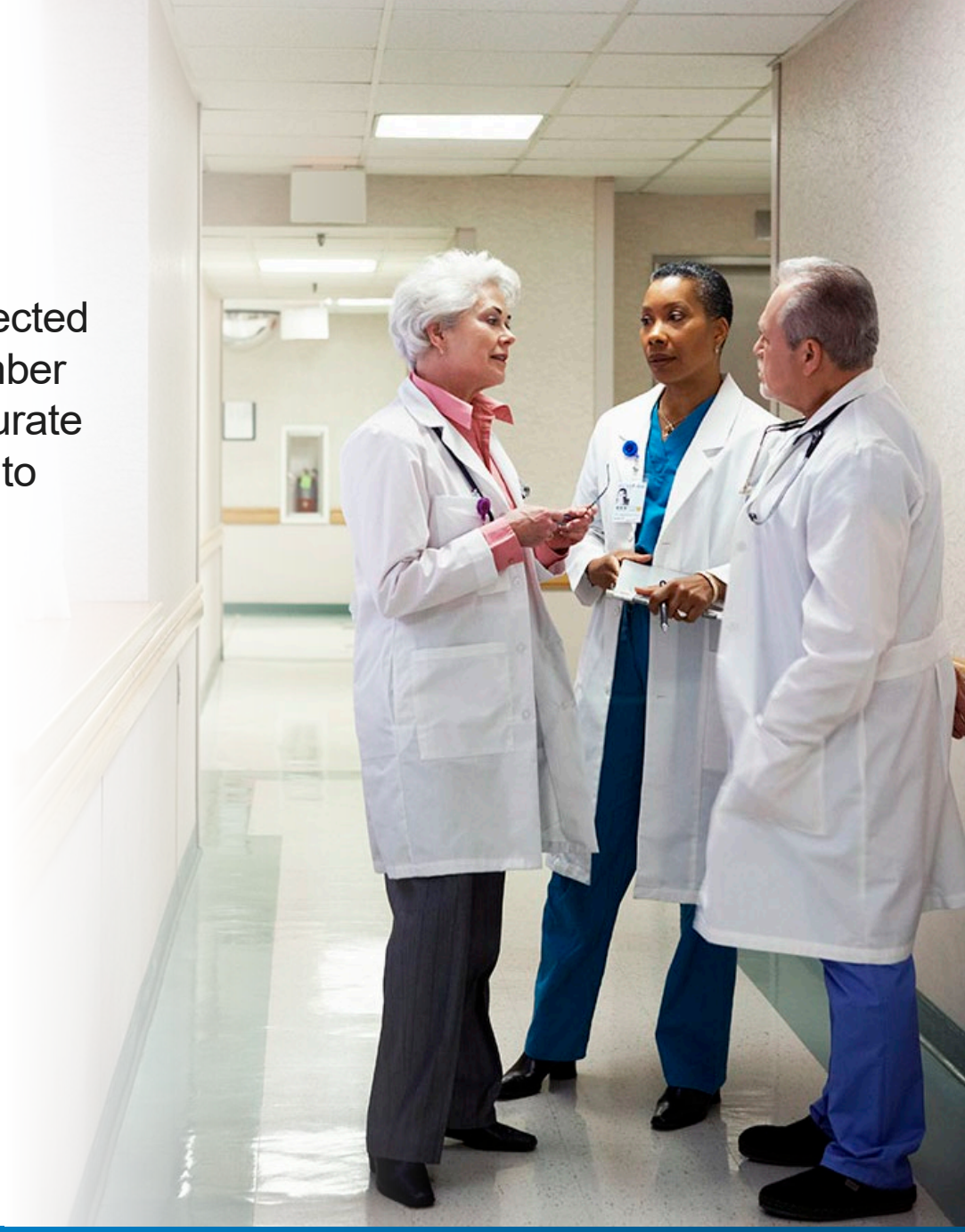
What's New for Turquoise Care

Blue Cross and Blue Shield of New Mexico • Provider Training • 2024

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) 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
- Appointment Standards/Timely access requirements
- Advanced Directives
- Denied Claims Education

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- Alternative Benefit Plan (ABP)
- Pregnancy-Related and Family Planning Services
- 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

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- Availity®
- Referrals

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- Timely Filing
- Best Practices
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- Provider Reference Manual
- Specialized Trainings
- Blue Review℠ Provider Newsletter
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Member Rights and Responsibilities

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- 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
- Children in State Custody (CISC)
- Juvenile Justice Facilities

Cultural and Linguistic Competency

- Annual Cultural Competency Training Requirement
- Resources

Fraud, Waste and Abuse

High-Volume Providers

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 Settings Rule Requirements, Agency-Based Community Benefit (ABCB), Self-Directed Community Benefit (SDCB), Electronic Visit Verification (EVV)
  - ABCB Program Recruitment
- Primary Care Provider Responsibilities
- Telehealth
- Medicaid Home Visiting (MHV)
- Trauma Informed Care

Participating with BCBSNM

Participation with Blue Cross and Blue Shield of New Mexico

- 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 Health Care Authority (HCA)
- 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 HCA
  - Provider Training Modules may be found on our website: bcbsnm.com/provider/training/index.html

Participating with BCBSNM

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

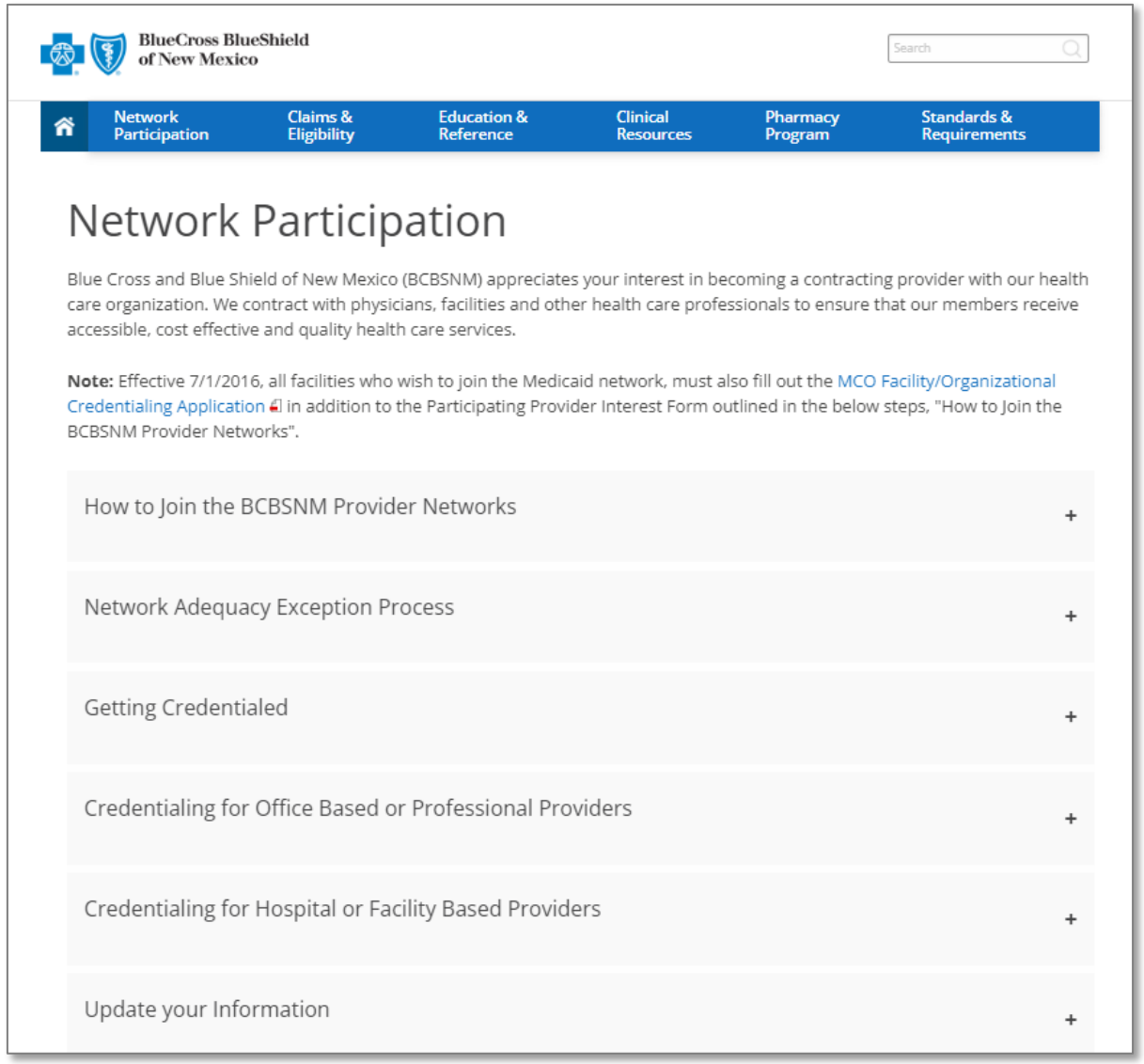
505-246-0710 or 800-299-7304

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). Onboarding 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 Credentialing – CAQH Application

HCA intends to implement centralized credentialing and recredentialing. Pending this implementation, please continue to follow the below process;

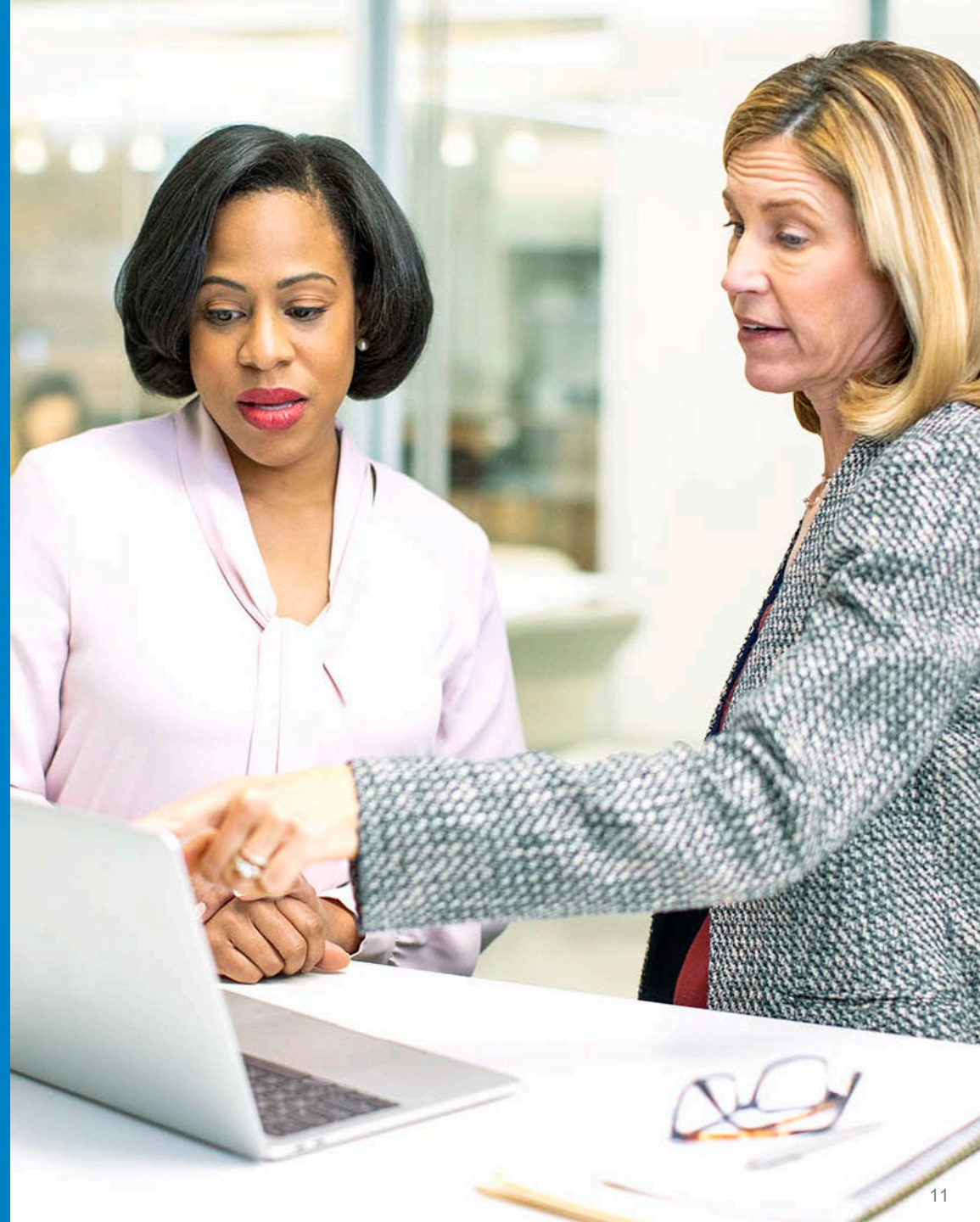
- Initial Credentialing with BCBSNM requires:
  - Compliance with all credentialing requirements to include, but not limited to, an active license that has not been revoked, terminated, probated or suspended
- Site Visits
  - Facilities and practitioners may require a site visit
  - BCBSNM will contact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

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

Provider Re-Credentialing

HCA intends to implement centralized credentialing and recredentialing. Pending this implementation, please continue to follow the below process;

- 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



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 Timely Access Requirements

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

BCBSNM will monitor compliance regularly and will provide education and potential corrective action to providers who fail to comply with timely access requirements.

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 Timely Access Requirements (cont.)

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**

Obligation to Timely Access Requirements

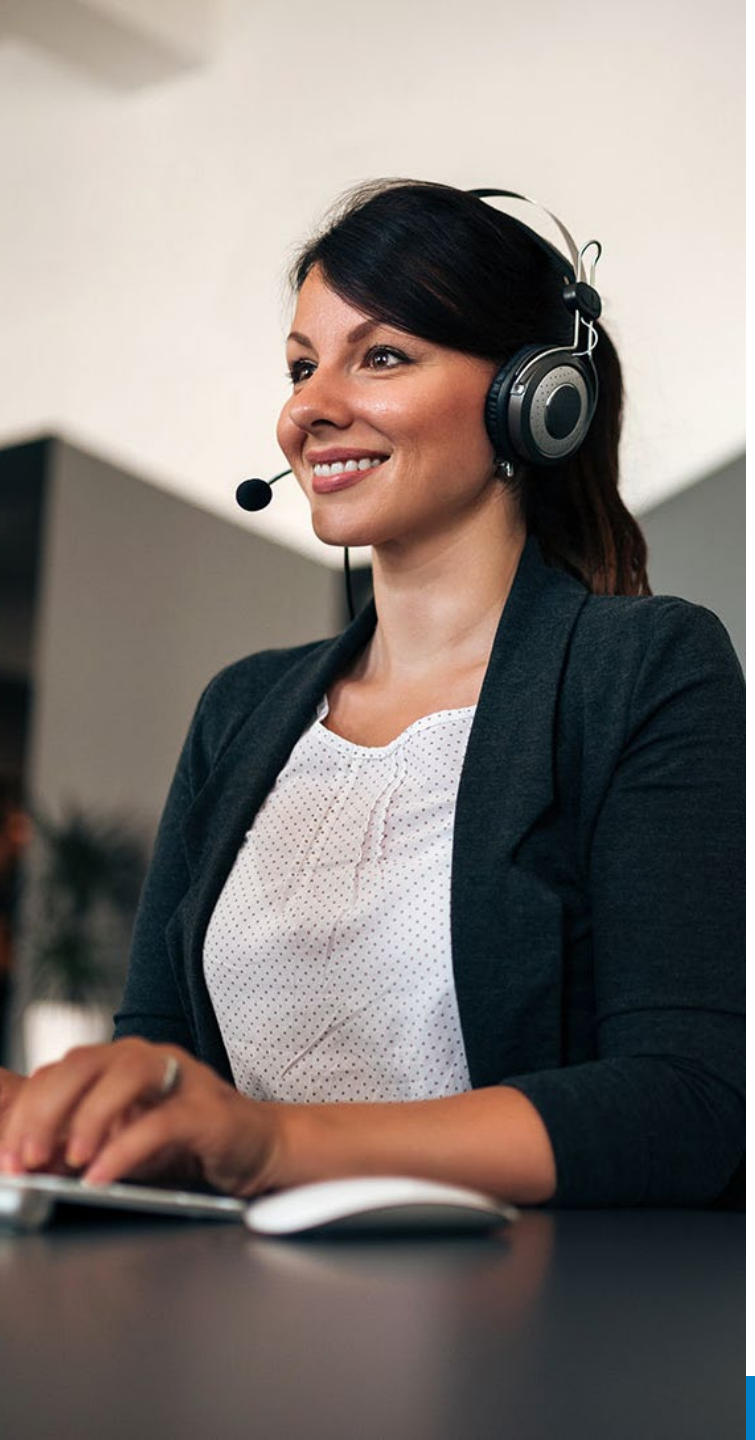
Behavioral Health Appointment Standards	
Routine	For non-urgent behavioral health care, the request-to-appointment time for an initial assessment shall be no more than **7 calendar days**, unless the member requests a later time. All non-urgent behavioral health care outpatient appointments shall be available within **30 calendar days**.
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 **90 minutes** of the request

Maternity Care Appointment Standards	
Urgent	For maternity care appointments, the request-to-appointment shall be no more than **24 hours** for urgent appointments.
Routine	For routine prenatal care appointments; ○ First trimester = within **14 calendar days** of the request ○ Second trimester = within **7 calendar days** of the request ○ Third trimester = within **3 business days** of the request

Advanced Directives

Blue Cross and Blue Shield of New Mexico (BCBSNM) recommends all of our plan members take the time to create a living will, designate a power of attorney and provide their advance directive to their primary care physician.

- Advance directives are written documents (such as a Living Will, Health Care Treatment Directives and Durable Power of Attorney) that give a person you select the responsibility for making health care decisions if they cannot express their own wishes. These documents also describe the kind of treatment they do and do not want. Such written instructions must comply with NMSA 1978, § 24-7A-1 through 24-7A-18 and 24-7B-1 through 24-7B-16.
- New Mexico's Mental Health Care Treatment Decisions Act allows member to put in writing their wishes for psychiatric treatment. This is called a Psychiatric Advance Directive (PAD). If a member is unable to make a decision, mental health advance directives will describe their wishes.
- Complaints about noncompliance with advance directive requirements may be filed with HCA/MAD Division of Health Improvement in the New Mexico Department of Health.
- Federal law states that hospitals, nursing homes and other providers have to tell members about advance directives. You need to explain the members legal choices about medical decisions. The law was made to members/patients more control during times when they may not be able to make health care decisions.



Denied Claims Provider Education

- BCBSNM will be monitoring provider's denied claims. Providers whose monthly volume of denied claims is 10% or more, will receive one on one training from the BCBSNM Provider Representative.

The purpose of the training is to correct the error(s) for resubmission (as applicable) and avoid future denials.

Telemedicine

Care When Your Patients Need It

Telemedicine provides your patients with convenient access to other health care professionals.

BCBSNM supports and encourages the use of telemedicine capabilities in order to improve access to and quality of care.

Please see the Telemedicine Quick Reference Guide located on our provider website:

bcbsnm.com\docs\provider\nm\telehealth-qrg-2022.pdf

Telemedicine Requirements

Interactive telehealth communication systems must include the following

- HIPPA-compliant live audio/video, real time two-way connection between the member and the provider.
- **The ability to store and forward the transmission of a health history to a Provider.**
- **Remote Member Monitoring –** the ability to use electronic tools to monitor and record a member's physiological status
- **Telephone Visits –** with the approval from HCA, limited professional services by telephone without video.
- **Compliance** with State guidelines for telemedicine equipment or connectivity and security of transmission lines etc.
- Cultural Sensitivity and Shared Values –
  - Providing competent care with regards to culture and language needs
  - Distribution of work sites across the state, including Native American sites
  - Coordination and technical assistance at either end of the network connection

*A secure telehealth software is not required during the COVID-19 federal public health emergency.

Post PHE Telehealth Services

- Post PHE telehealth services will be covered as defined in **NMAC 8.310.2- Health Care Professional Services.**
- Telephone visits will continue to be allowed as they have been during the PHE, including in a member's home.
- This flexibility **ends December 31, 2024**

Covered Services

Alternative Benefit Plan (ABP)

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

The ABP offers coverage for Medicaid-eligible adults ages 19-64 who have income up to 133% 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 benefits/services have not changed under Turquoise Care, only Care Coordination requirements for the maternity population.
- The Turquoise Care contract requires that the MCOs fully delegate Care Coordination services for all prenatal and postpartum Members.
- This means that the MCOs will no longer provide care coordination services to their maternity populations but rather “delegate” it to community-based organizations and maternity providers, such as OB-GYNs.
- BCBSNM expects to contract with about 10 delegated care coordination entities for its general maternity population and with Early Intervention agencies for the delegation of care coordination for the CARA population (babies born exposed to substances)
- For family planning services members may self-refer to a provider and prior authorization is not required for family planning services.
- If a pregnant woman in the third trimester of pregnancy has an established relationship with an obstetrical provider, they may continue to be treated even if the provider is not contracted with BCBSNM.

2024 Turquoise Care
Value Added Services (VAS)

Medicaid Benefits for All of Life's Moments

As a Blue Cross and Blue Shield of New Mexico Medicaid member, you may get more than the standard Medicaid benefits. You may get extra services to keep you and your family healthy, too. Call Member Services at 1-866-689-1523 (TTY: 711) to find out if you are eligible.

Turquoise Care members may have access to value added services such as:

After School Youth Activities

- Covers fees for after school or sports activities for members under 18 years old

Infant Car Seat and Portable Infant Crib

- Pregnant Members who complete prenatal visit requirements and are engaged in Care Coordination.

Prenatal Education

- In-person prenatal community classes at partner hospitals in Albuquerque and Roswell.

Infant Diapers

- Available to pregnant members and new moms for the 1st month from birth.

Remote Monitoring Program

- Medical devices for chronic health conditions, who need to have their blood pressure and oxygen levels checked in real time.

Learn to Live

- Online digital behavioral health program for members 13 years and older and their caregivers, who deal with anxiety, stress, depression, sleep problems, and more.

Native American Traditional Healing Benefit

- Grant available to Native American members for traditional healing practices for the treatment of diagnosed conditions.

Friends and Family Circle

- Provides respite care for parents/caretakers who are caring for family members with complex needs.

Home Meal Delivery

- Provides nutritious meals to members who transition from an inpatient or long-term facility to the community, and to pregnant members with certain conditions.

Shower Chair

- For elderly or members with disabilities who need a convenience shower chair.

All value-added services do have limitations and/ or prior authorization requirements. Additional information will be provided separately with a listing of the vas and its limits and/ requirements.

Medicaid Benefits for All of Life's Moments

As a Blue Cross and Blue Shield of New Mexico Medicaid member, you may get more than the standard Medicaid benefits. You may get extra services to keep you and your family healthy, too. Call Member Services at 1-866-689-1523 (TTY: 711) to find out if you are eligible.

Turquoise Care members may have access to value added services such as:

Respite Bed

- Provides a temporary bed for members discharging from an emergency room or hospital who are medically vulnerable.

Wellness Centers

- Provides family support to access peer and family driven behavioral health recovery services to help members improve their health outcomes and provide education and resources.

Electroconvulsive Therapy (ECT)

- Members who meet standard ECT medical necessity criteria.

Epic Home + Health Partnership

- For members in Bernalillo County that are experiencing chronic homelessness with severe mental illness.

Care Giver Thank You Package

- Provides family caregivers a gift package and educational materials.

Lifestyle Modification Support for Nutrition and Fitness

- Members can get 24/7 virtual access to health experts, tools and live events to help modify diet, fitness and lifestyle to get healthy

Resource Tool Kit

- For justice involved members and members experiencing homelessness. Tool kit includes resource information.

Transitional Living for Chemically Dependent Psychiatrically Impaired Adults

- For members 18 years or older enrolled in an outpatient substance abuse center or in active treatment for psychiatric issues, who have an identified plan to return to independent living.

Assistance with Social Determinants of Care (SDoH)

- BCBSNM will provide support to members with aid in areas classified as SDOH to meet their care plan goals.

All value-added services do have limitations and/ or prior authorization requirements. Additional information will be provided separately with a listing of the vas and its limits and/ requirements.

Reminders about Newborns

- When a child is born to a mother enrolled with Blue Cross and Blue Sheild of New Mexico, 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 Health Care Authority 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 Carelon 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 BCBSNM members. ModivCare is our contracted vendor.

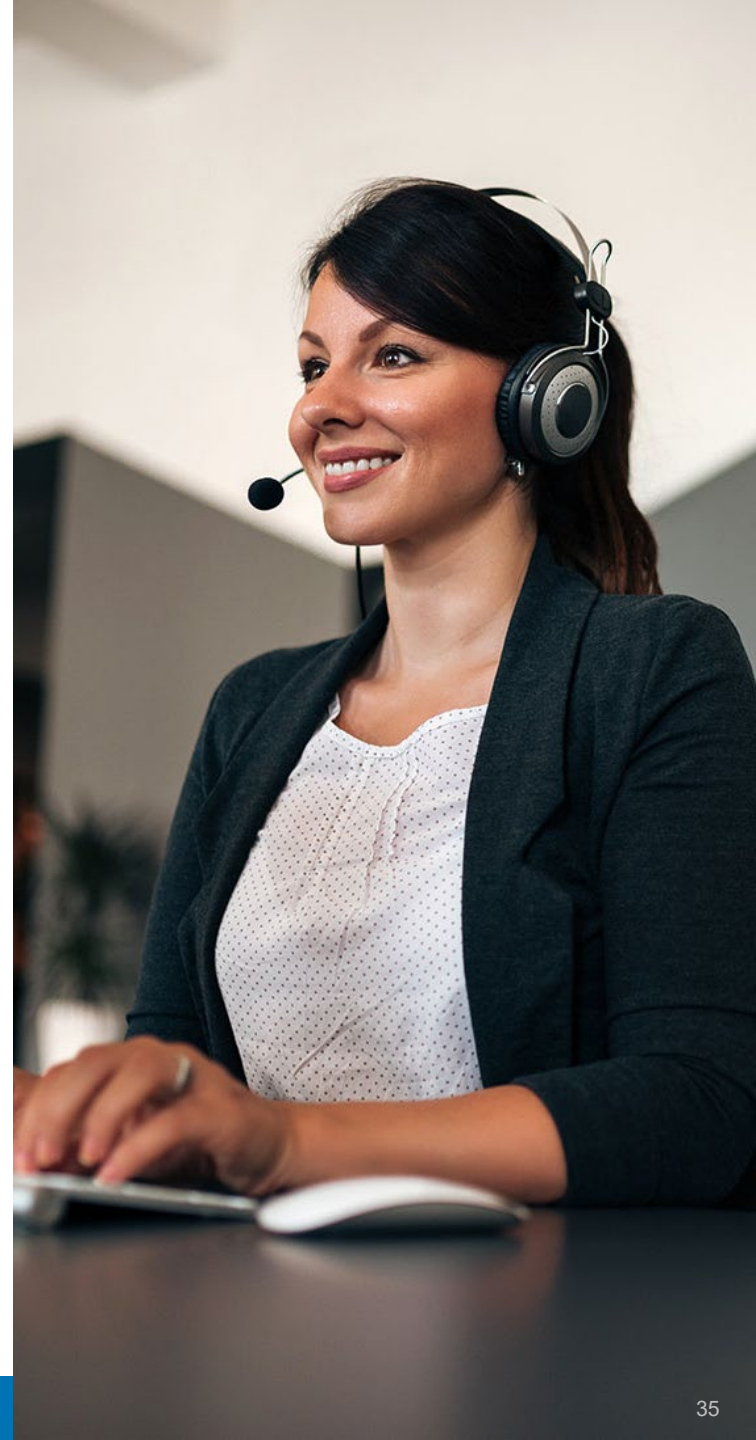
- ModivCare provides rides to and from medical appointments or mileage reimbursement. Special needs are accommodated.
- ModivCare may obtain or ask the member (or member's parent or representative) to obtain verification that an appointment has taken place.
- NEMT helps to lower appointment "no-shows."
- 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 Behavioral Health and Physical Health housing specialists 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.**



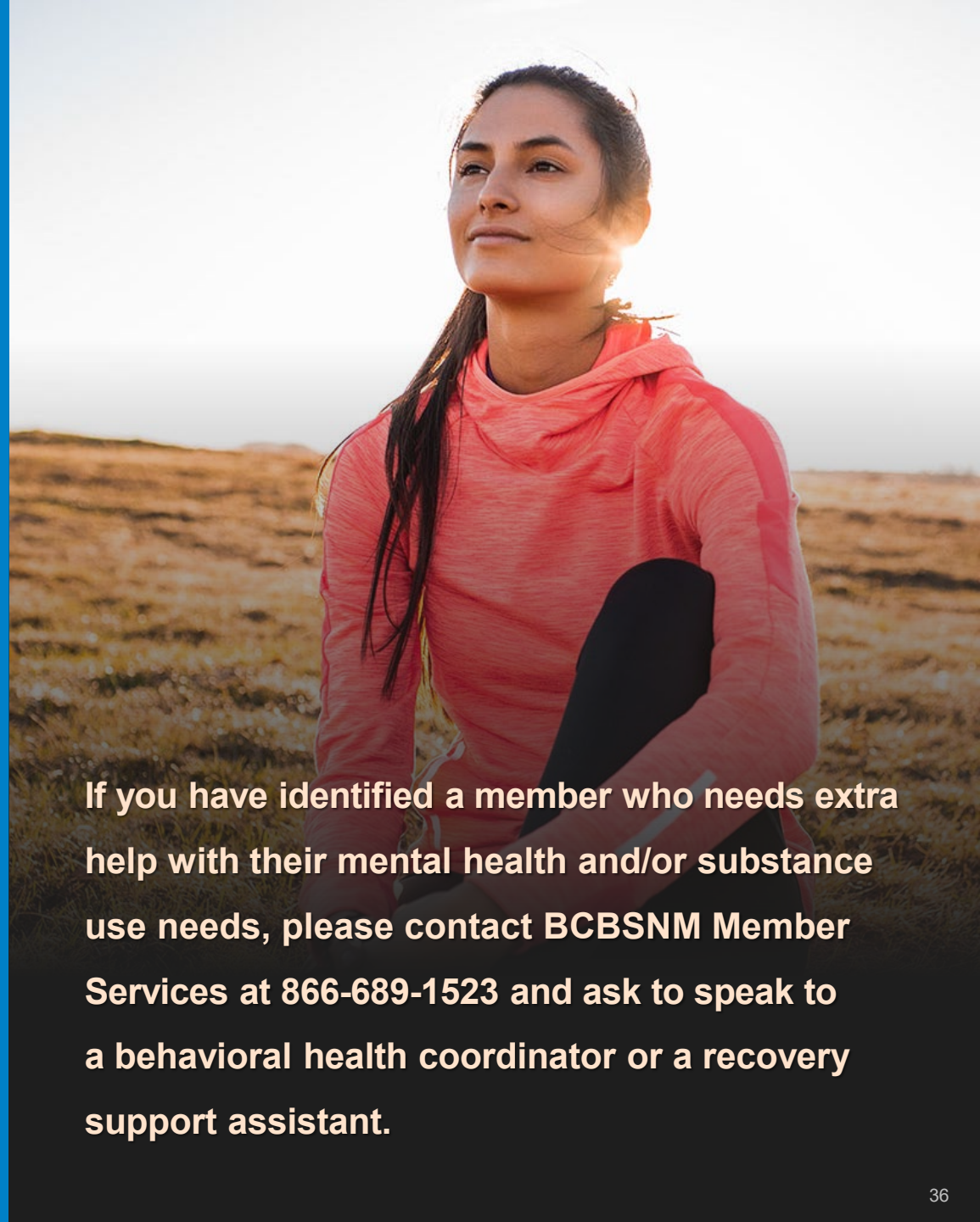
Identification of Substance Use Disorder and Serious Mental Illness

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.

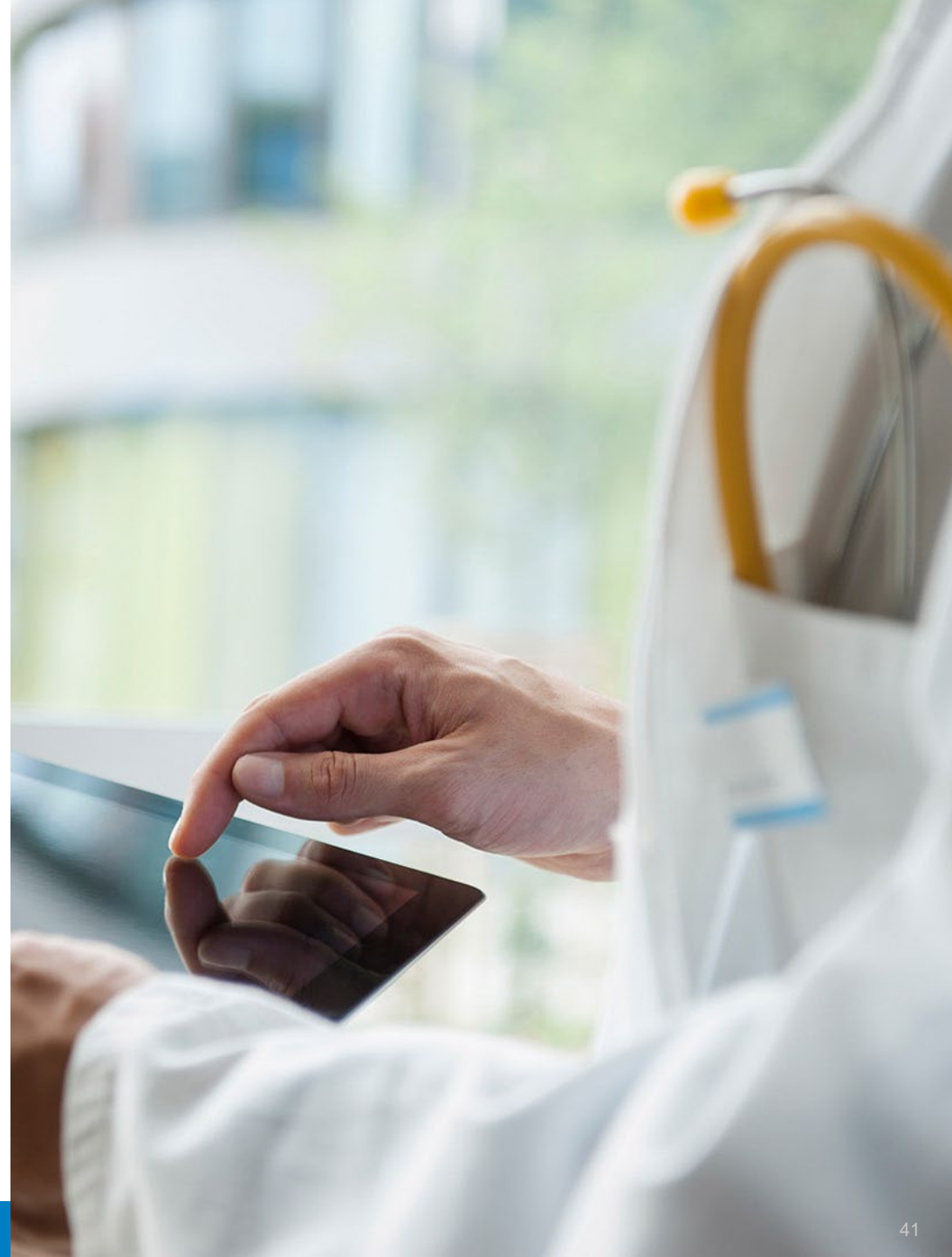
Services performed without preauthorization may be denied for payment, and the rendering provider may not seek reimbursement from members.

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 Calendar 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 members over 18 years old, 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 and Blue Shield of New Mexico 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

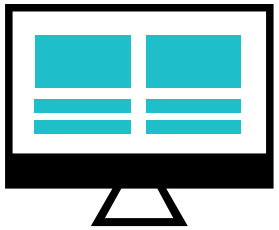
Visit Information

- 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

! Reminder to Providers

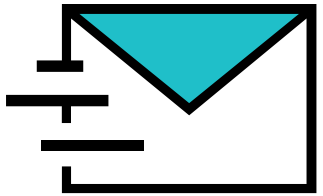
- Before submitting claim, validate that all charges are listed, and all necessary information has been provided to avoid late charges and/or corrected claims.

How to Submit Claims



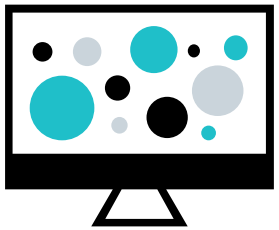
Electronic Submission

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



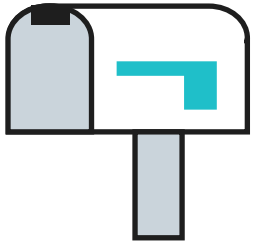
Paper Submission

- 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, prior to resubmitting to prevent denials



Submit forms to:

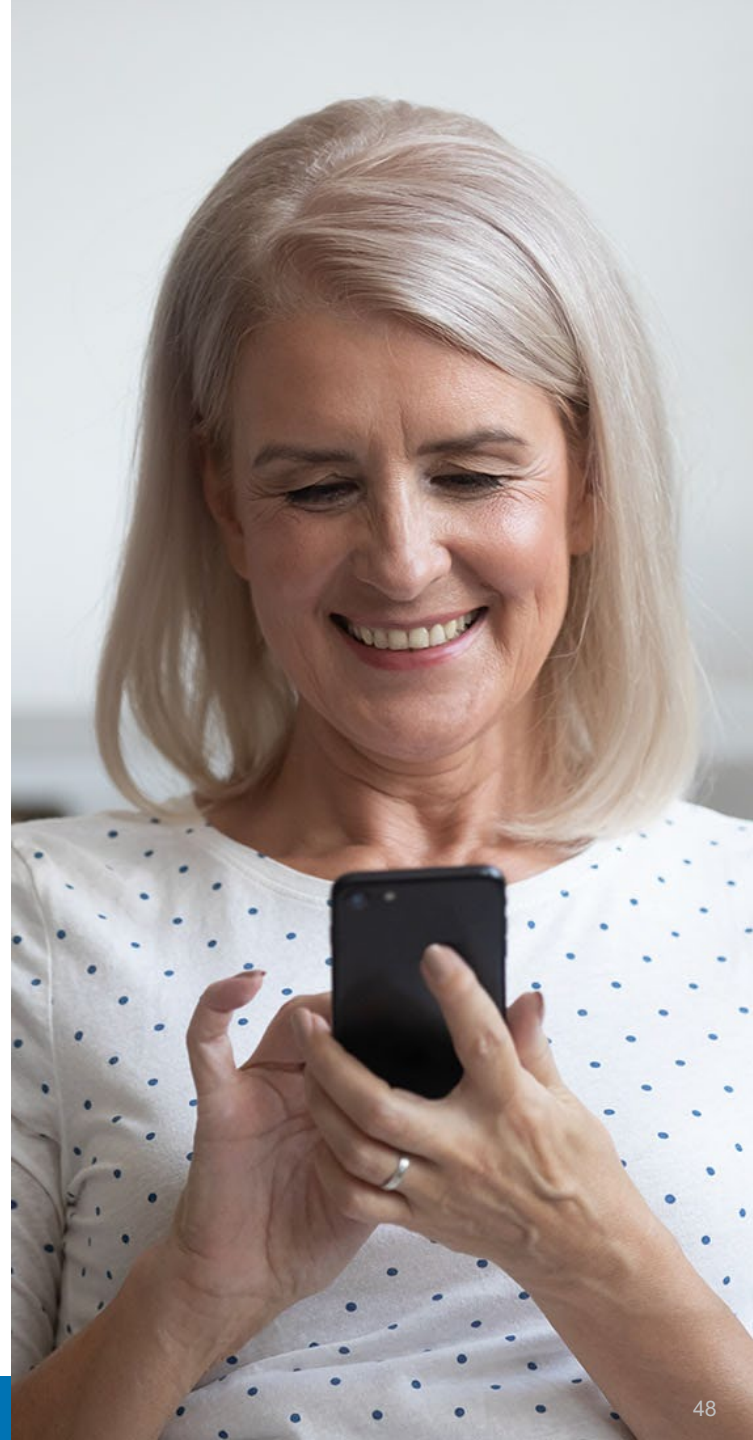
- **Claims:** BCBSNM, P.O. Box 650712 Dallas, TX 75265-0712
- **Appeals:** BCBSNM, P.O. Box 660717 Dallas, TX 75266-0717

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 HCA or the MCO.

Additional Claims Reminders

Coordination of Benefits (COB)

- Blue Cross and Blue Shield of New Mexico Medicaid Managed Care plan is always the payer of last resort
- Claims should be submitted with the complete primary insurance Explanation of Benefits or primary insurance payment information if submitted electronically
- For members with both Medicare and Medicaid, Medicare is considered the member's primary insurance

Encounter Reporting

- BCBSNM is required by HCA to report ALL services rendered to Blue Cross and Blue Shield of New Mexico Medicaid Managed Care plan 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; HCA 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.

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 660058
Dallas, TX 75266-0058

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.

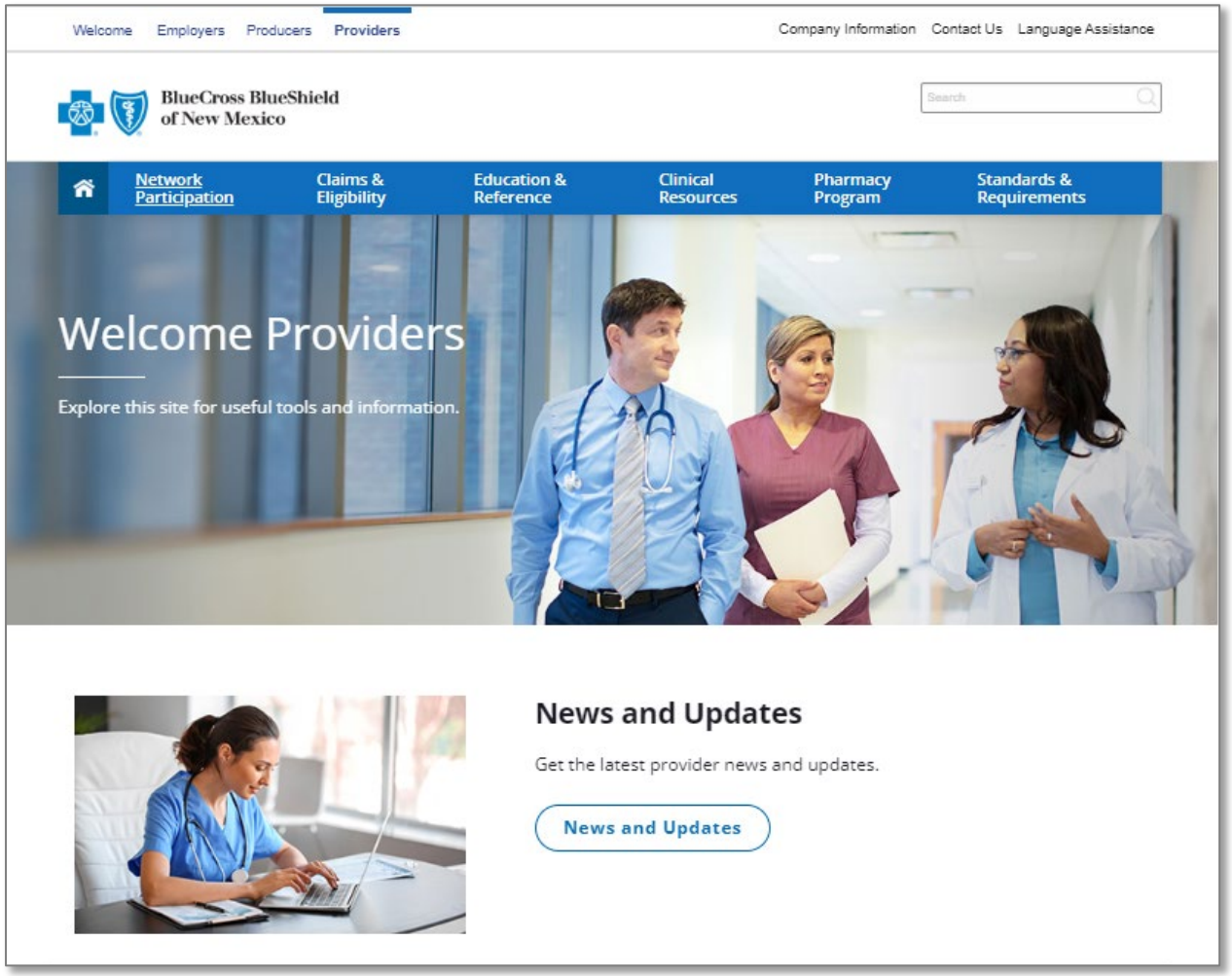
Provider Resources

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.

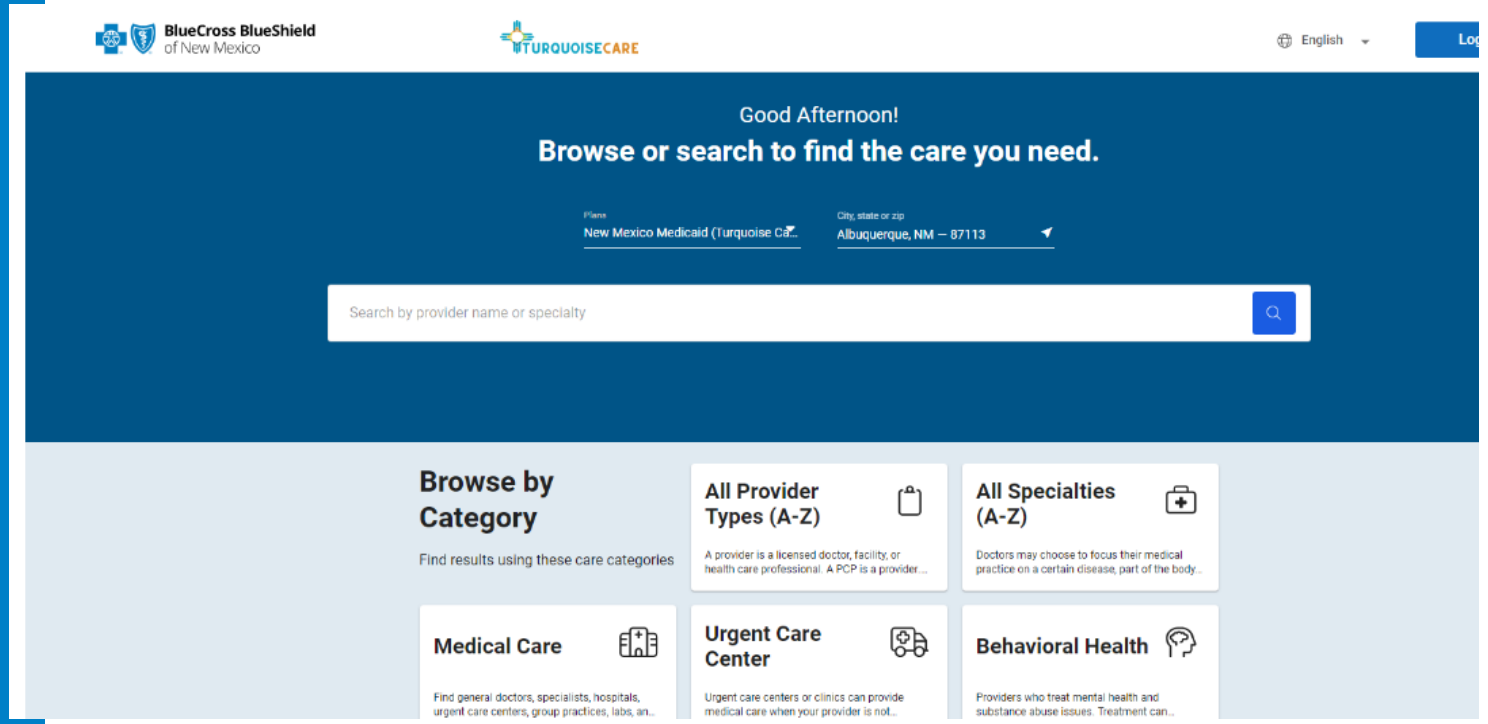
For the most up to date list of Provider Representative assignments, please visit

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 and Blue Shield of New Mexico Medicaid (Turquoise Care)**
- 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

- Medicaid income determination and enrollment processes are completed by the Income Support Division of HCA.
- 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 HCA 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 HCA based on factors such as if the MCO is new to Turquoise Care quality measures, cost or utilization management performance or other determinants at HCA's discretion. HCA 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

For Blue Cross New Mexico Medicaid℠ members, there is nothing they need to do to keep their benefits. Members will have all the health care benefits they had with Centennial Care plus more with Turquoise Care.

Members may call, write or visit our website for questions regarding Turquoise 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 and Blue Shield of New Mexico
P.O. Box 650712
Dallas, TX 75265-0712

Website:
https://www.bcbsnm.com/turquoise-care-welcome

Medicaid 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: ombudsman@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 not dually enrolled with BCBSNM may see any Medicare-participating PCP and should present both ID cards when visiting a provider.
  - 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 – Turquoise Care and ABP

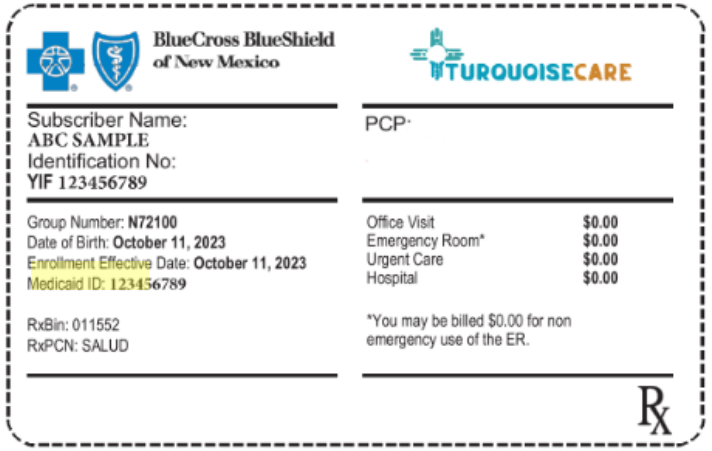
The front of the card includes:

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

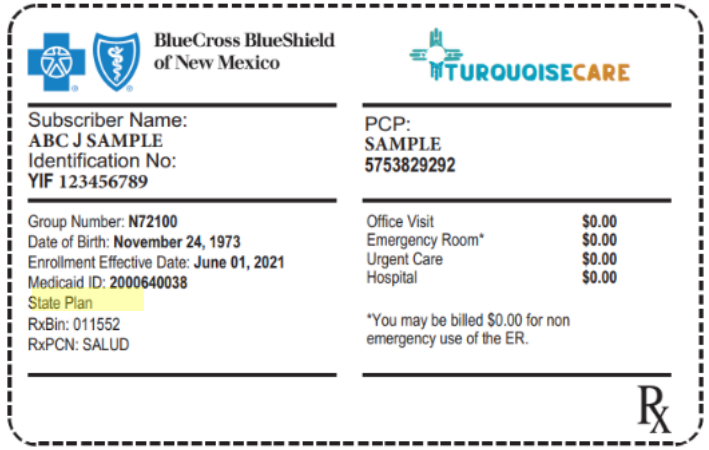
The back of the card includes:

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

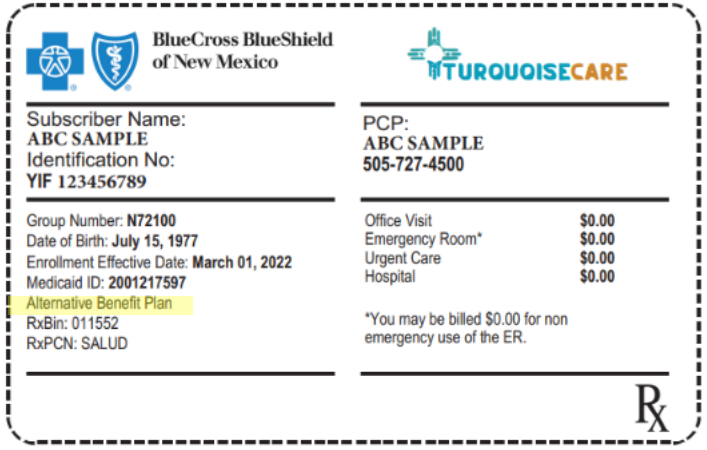
Full Medicaid


BlueCross BlueShield of New Mexico
TURQUOISECARE
Subscriber Name:
ABC SAMPLE
Identification No:
YIF 123456789
PCP:
Group Number: N72100
Date of Birth: October 11, 2023
Enrollment Effective Date: October 11, 2023
Medicaid ID: 123456789
RxBin: 011552
RxPCN: SALUD
Office Visit $0.00
Emergency Room* $0.00
Urgent Care $0.00
Hospital $0.00
*You may be billed $0.00 for non emergency use of the ER.
Rx

State Plan


BlueCross BlueShield of New Mexico
TURQUOISECARE
Subscriber Name:
ABC J SAMPLE
Identification No:
YIF 123456789
PCP:
SAMPLE
5753829292
Group Number: N72100
Date of Birth: November 24, 1973
Enrollment Effective Date: June 01, 2021
Medicaid ID: 2000640038
State Plan
RxBin: 011552
RxPCN: SALUD
Office Visit $0.00
Emergency Room* $0.00
Urgent Care $0.00
Hospital $0.00
*You may be billed $0.00 for non emergency use of the ER.
Rx

Alternative Benefit Plan (ABP)


BlueCross BlueShield of New Mexico
TURQUOISECARE
Subscriber Name:
ABC SAMPLE
Identification No:
YIF 123456789
PCP:
ABC SAMPLE
505-727-4500
Group Number: N72100
Date of Birth: July 15, 1977
Enrollment Effective Date: March 01, 2022
Medicaid ID: 2001217597
Alternative Benefit Plan
RxBin: 011552
RxPCN: SALUD
Office Visit $0.00
Emergency Room* $0.00
Urgent Care $0.00
Hospital $0.00
*You may be billed $0.00 for non emergency use of the ER.
Rx

Back of Card


bcbsnm.com
BlueCross BlueShield of New Mexico
For care received in/outside of NM:
BCBSNM Claims Dept
PO Box 27838
Albuquerque NM 87125-7838
Prior authorization required for some in-network and most out-of-network services. Special Beginnings® members must call in the first Trimester of pregnancy. For emergencies, call 911 or go to the closest emergency room. After treatment call your PCP.
PRIME THERAPEUTICS
Customer Service 1-866-689-1523
Special Beginnings 1-888-421-7781
24/7 Nurseline 1-877-213-2567
Ride Assist* 1-866-418-9829
ReserveTransport* 1-866-913-4342
*Group contracts directly.
Blue Cross Blue Shield of New Mexico, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross Blue Shield Association
Pharmacy Benefits Manager

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 to leave a message. We will return your call within 24 business hours.

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 Medicaid Managed Care operations, 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 and Blue Shield of New Mexico
Attn: Turquoise Care Appeals and Grievance Coordinator
P.O. Box 660717
Dallas, TX 75266-0717

Email: GPDAG@bcbsnm.com

A&G Timeline

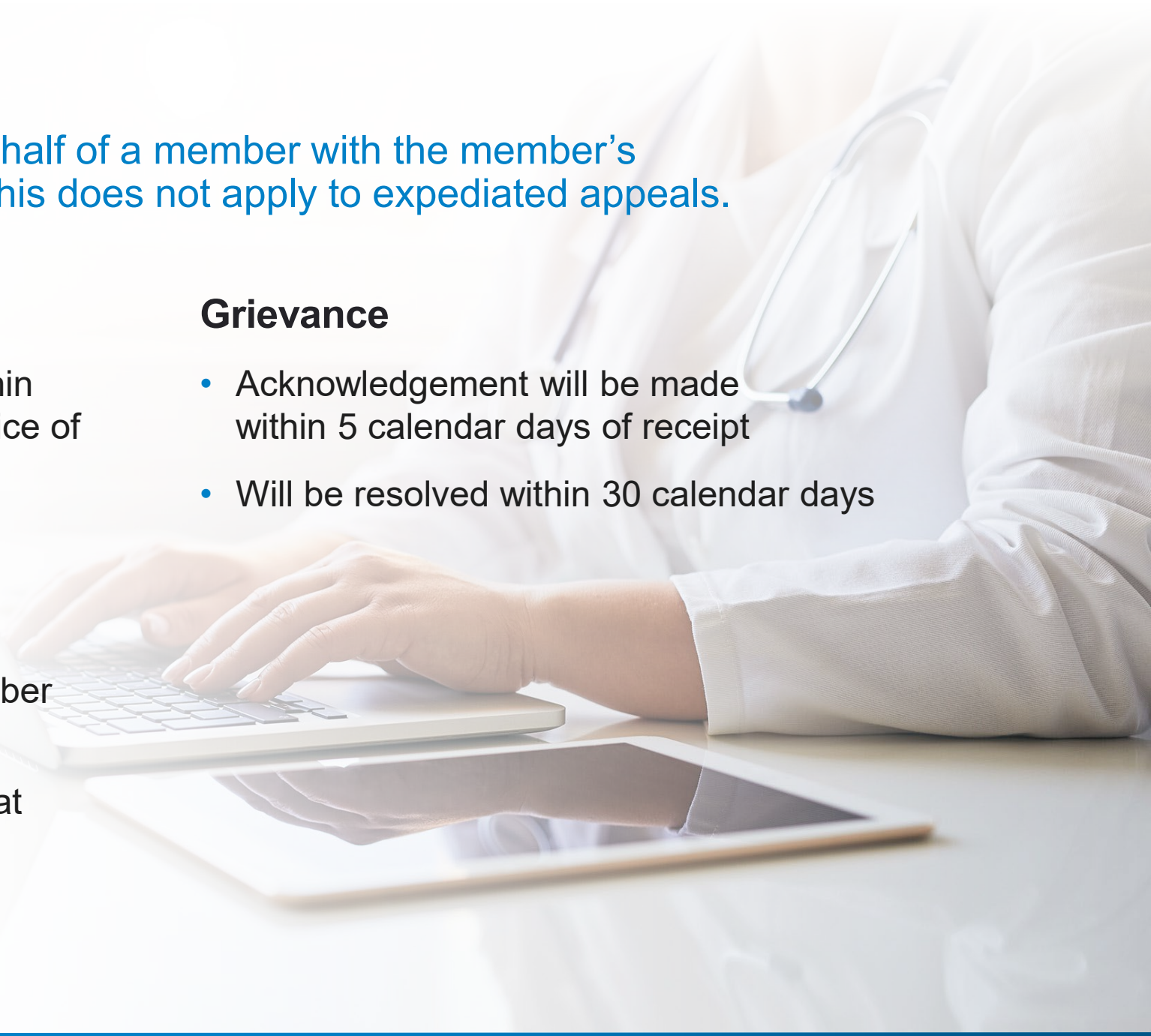
Providers may request an appeal on behalf of a member with the member's authorization for pre-service appeals. This does not apply to expediated appeals.

Appeal

- Need to be requested by the provider within 60 calendar days from the date of 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
- HCA 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 sends 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 HCA 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 and Blue Shield of New Mexico 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 HCA Portal

Please refer to this section in the Provider Reference Manual

- A critical incident is any occurrence that represents actual or potential serious harm to the well-being of a member or others.
  - Reporting a critical incident helps:
    - Ensure that everyone assisting the member has the most current information;
    - Address potential gaps in the member's care;
    - Expedite actions to help meet the member's needs.

- Allegations of abuse, neglect (including self-neglect), exploitation, sentinel events (severe harm), deaths (expected and unexpected), emergency services, law enforcement, environmental hazards, and elopement/missing for select Categories of Eligibility (COEs) must be reported to HCA through the Critical Incident Reporting ("CIR") system portal at criticalincident.hsd.state.nm.us. Additional COEs may be reported outside of the portal.

Critical Incident Reporting (CIR)

- All physical and behavioral health contracted providers are required to attend the annual critical incidents training.
- Critical Incident Reporting (CIR) should be filed within 24 hours of knowledge of an incident; file the next business day in the event.
- Personal Care Service (PCS) providers are required to file CIR's for "Neglect/Insufficient Staffing". Documentation of follow-up conducted will be entered into the CIR diary entry according to "Risk Level"
  - Some examples are:
    - Agency has not had a caregiver to send out for an extended period
    - Member is a fall risk with no natural support
    - Members caregiver was scheduled to work 9am-5pm, but was only able to stay until 2pm
- 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

Critical Incident Reporting & Member Access to Services

- To help members access the services available, providers can direct members to call the number on the back of their card.
- BCBSNM will conduct telephonic outreach to the member. This will serve as an opportunity to discuss our members' health, safety, and wellbeing. We also discuss services available such as medical care, counseling and/or support, in the event the member has been impacted by a critical incident.
- We at BCBSNM prioritize the health, wellness, and safety of our members and inform them that they have access to necessary services throughout the incident reporting and investigation process. We also provide clear instructions on how members can access these services, including contact information for support resources and any available emergency hotlines..

Home and Community Based Service (HCBS) Providers

HCBS Final Settings Rule Annual Attestation/Screening Tool and Audit

HCBS Providers will be required to complete an annual Attestation & Screening tool, along with an on-site audit completed by one of the Managed Care Organizations (MCO).

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 Turquoise 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

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
- Health related social needs
- Polypharmacy (use of six or more different medications)
- High in-patient admissions
- High emergency room usage
- 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

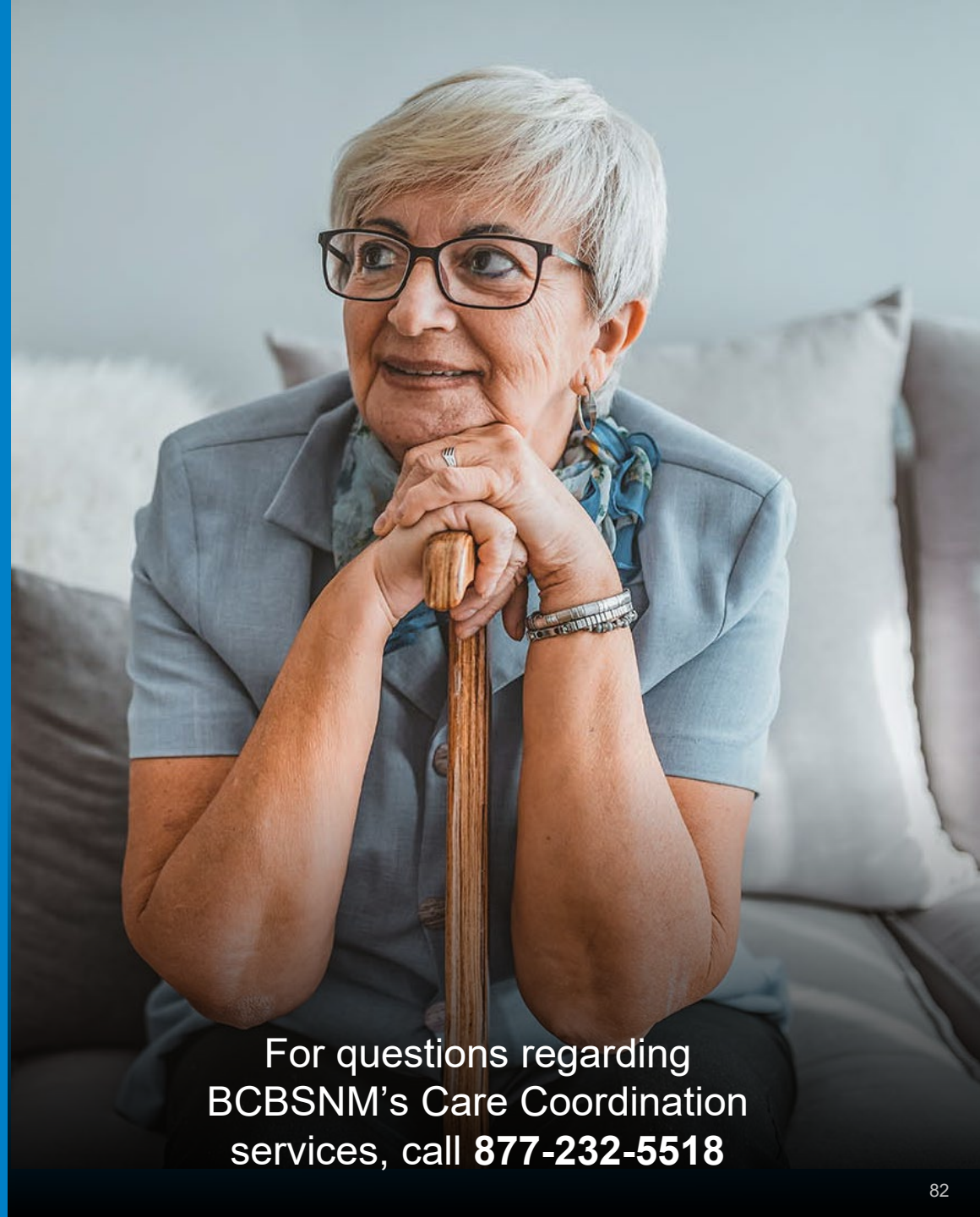
Types of Care Coordination

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



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 (CNA)

- 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 HCA 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

- Children in State Custody
- Dual Special Needs Members
- Refugees
- Behavioral Health
- Members in Nursing Facilities
- Members with Brain Injury
- 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
- 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 (CISC)

- All members that are considered CISC will be enrolled through Presbyterian Health Plan.
  - Native American members can choose the MCO they would like to be enrolled in.
- 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.

No Reject and No Eject Provision

Comprehensive Community Support Services (CCSS) and High Fidelity Wraparound (HFW) Provider types must follow the no reject and no eject provision as defined below for CISC members

- **No Reject** = the provider must accept the referral for eligibility and medical necessity determination. If the Member is Medicaid eligible, meets the Serious Emotional Disturbance (SED) criteria, and meets medical necessity, the provider must coordinate all needed services through CCSS and HFW service providers for CISC. A provider will not discriminate against nor use any policy to practice that has the effect of discrimination against an individual on the basis of health status or need for services.

- **No Eject** = the provider must continue to coordinate services and assist Members in accessing appropriate services and supports.

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.

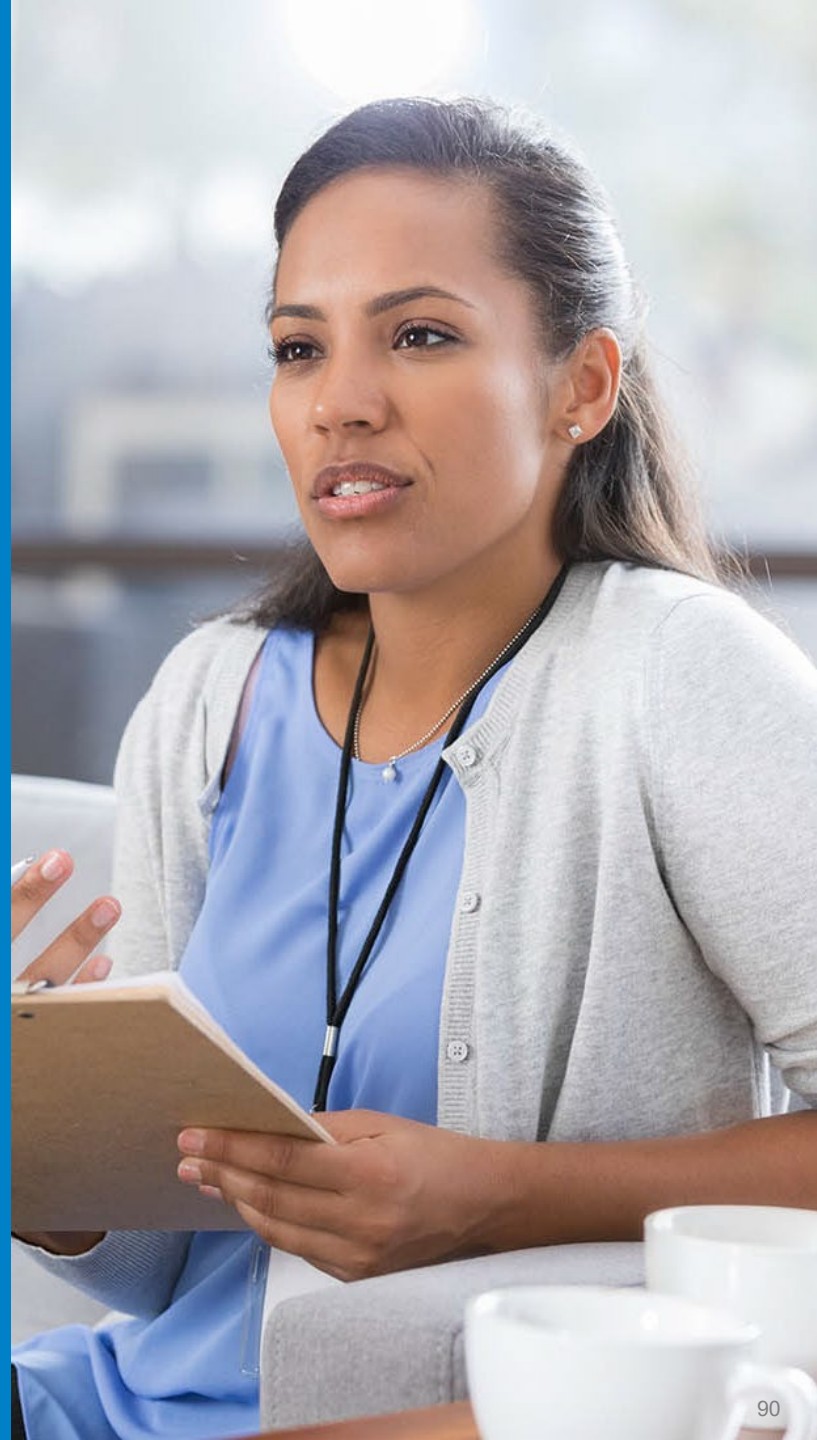
BCBSNM Supports the Improvement of Delivery Systems

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 and Blue Shield of New Mexico Medicaid Managed Care 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

Juvenile Justice Facilities and Care Coordination

- BCBSNM has a Behavioral Health Care Coordination (BHCC) specialty team called, Transition of Care, they are assigned to every Juvenile incarcerated member and engage with members, Justice Facilities, Member's families and other stakeholders.
- A BHCC utilizes tools such as a Transition of Care Assessment & creation of Care Plan goals focused on a successful transition
- Assist Juvenile Facilities with Transition Planning which can include various treatment levels (Residential Treatment Center, Treatment Foster Care, Outpatient, etc.)
- Participate in Team Meetings
- Post-Release contact with members to ensure continuity of care
- Be a resource to In-Network Providers and BCBSNM Plan Benefits

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 and Blue Shield of New Mexico 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 Health Care Authority (HCA) for all contracted providers.

- 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:

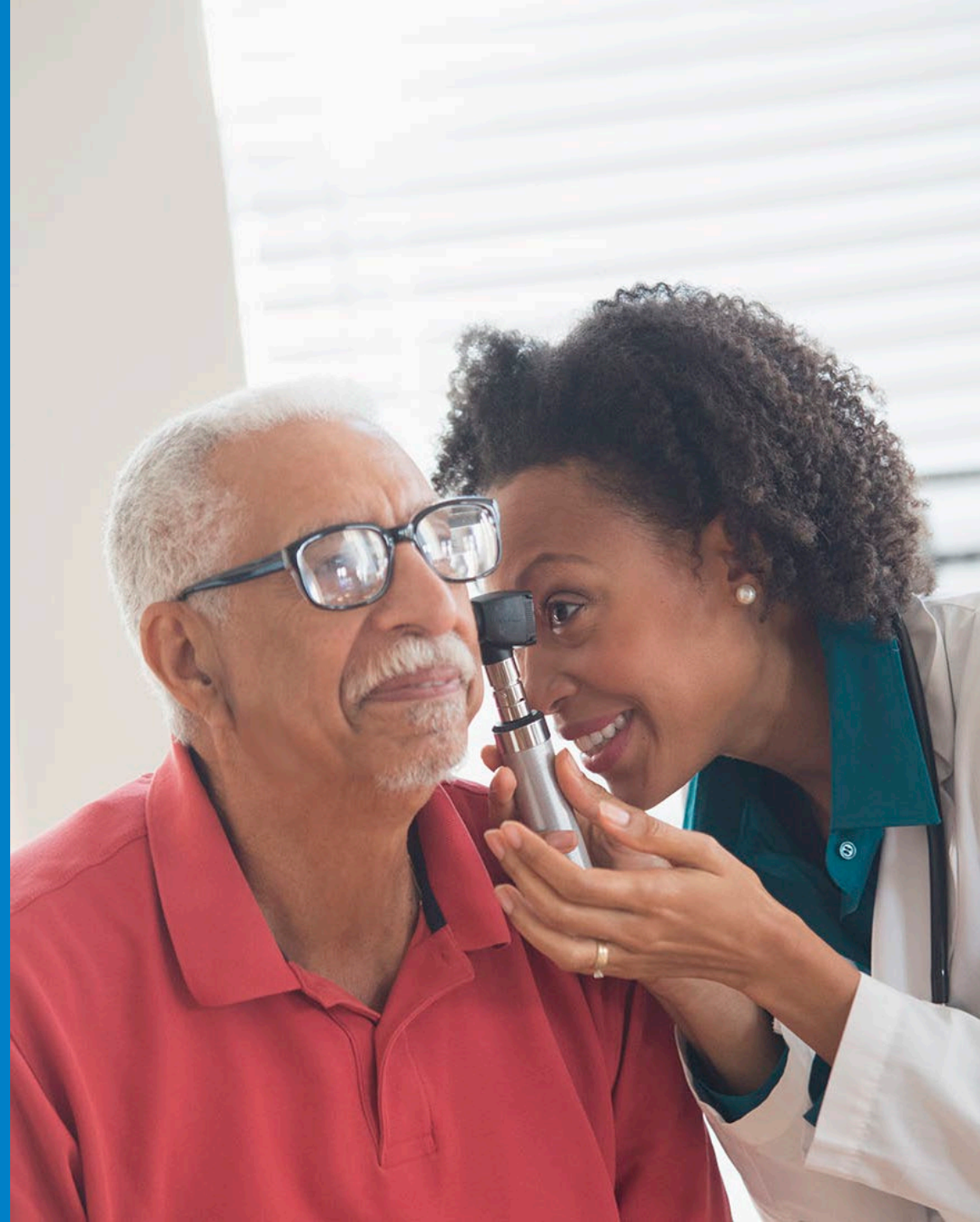
- Suspected fraud, waste and abuse should be reported to the BCBSNM Special Investigations Department (SID) by health care providers, subcontractors, vendors, members and other departments
  - **Fraud:** An intentional deception or misrepresentation by a person or an entity with the knowledge that the 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.



Questions?