# Implementation Target 6.1

*HSD will reinstate language in its Medicaid contracts to prevent children from being rejected or removed from behavioral health services providers. HSD will work with providers to identify and remove other administrative barriers to providing services.*

## Background on No Reject/No Eject Language

Prior to the implementation of Centennial Care, the state administered Medicaid and various other programs under seven different federal Medicaid waivers. Additionally, behavioral health was "carved-out" from the Medicaid physical health managed care program and was operated under its own 1915B Waiver. In 2014, HSD integrated behavioral health, long-term services and supports (LTSS), and physical health (PH) into a Medicaid 1115 Demonstration Waiver. This integrated program is currently known as Centennial Care.

Based on research conducted by HSD, neither the Medicaid contracts with the managed care organizations (MCOs) nor the previous Medicaid Behavioral Health statewide entity (OptumHealth) contract contained language preventing children from being rejected or removed from behavioral health services providers. HSD discovered the "no reject/no eject" language was included in the OptumHealth provider agreements with direct service providers, specifically core service agencies (CSAs). However, the original provision applied to Comprehensive Community Support Services (CCSS) only and, at that time, CSAs were the sole providers of CCSS. The original language in the OptumHealth provider contracts stated:

> *Does not "reject" or "eject" consumers who meet the definition of CSA Eligibility within the designated LC or County.*
>
> *"No Reject" was a requirement the agency must accept the referral for eligibility determination, and if eligible, provide or coordinate services (as described in section B.iv. above) within funding availability.*
>
> *No "Eject" was a requirement where the agency was to continue to follow the consumer through all levels of care and movement within the system(s)*
>
> (See approved CSA Facts-At-A-Glance Core Service Agency: No Reject; No Eject" dated April 2011.)

During that period, the CSAs were full-service behavioral health-home-type providers expected to offer and provide (or make provision for) a full array of behavioral health services for individuals with behavioral health needs referred by OptumHealth, the

behavioral health statewide entity and a managed care organization. OptumHealth operated as the statewide entity from 2009–2013. In 2009, there were 11 CSAs, grown to 31 by 2015. The state moved away from CSA designations and expanded the number and types of providers that could provide CCSS.

Currently, there are 67 CCSS Medicaid enrolled providers in New Mexico and 54 of these providers serve children. The New Mexico Administrative Code (NMAC) 8.321.2.18, effective 1/1/2020 outlines provider requirements for CCSS.

Lastly, HSD and CYFD met with a team of behavioral health providers in February 2021 to solicit feedback on their experience with the no reject/no eject provision under OptumHealth. The providers identified the following barriers to implementation:

1. Lack of sufficiently trained staff to work with SED CISC;
2. Lack of specialty services to meet the needs of a child with high acuity or complexity of symptoms; and
3. Lack of sufficient reimbursement.

## Resolution for No Eject/No Reject Requirement

Under Centennial Care, Federally Qualified Health Centers (FQHCs), Community Mental Health Centers (CMHCs), Indian Health Services (IHS), Health Homes, and CSAs provide CCSS. HSD required the MCOs to include the no reject/no eject language in their contracts for providers who provide CCSS and High-Fidelity Wraparound (HFW). This expands the number of providers that will be expected to adhere to the no reject/no eject provision.

CCSS and HFW are the two core services and models selected for the provision of the no reject/no eject requirement because these services include Care Coordination that bring all stakeholders and providers into a team-based planning process to determine the services and supports needed for the child in state custody (CISC). The State is moving to a team-based approach for determining behavioral health needs (the individualized planning meeting process). Additionally, Care Coordination offered by CCSS and HFW provide a tiered approach of Care Coordination based on level of need and functional impairment and will be available to all CISC. HSD and CYFD will evaluate implementing this provision in other congregate settings that are CYFD funded, such as shelter care.

On November 1, 2021 the State issued LOD 69 that included requirements for D. IT 5.1, D. IT 6.1, D. IT 7.1 and D.IT 9.1. The LOD was "repealed and replaced" with LOD 69-1 (and issued to the MCOs on March 18, 2022). LOD 69 was sunset upon issuance of LOD 69-1 and LOD 69-1 will remain in effect until all requirements are incorporated into the Managed Care Services Agreement. LOD 69-1: D9 - IT 5.1 - MCO LOC 69-1 Requirements for CISC.pdf

In order to monitor the D. IT 6.1 requirements for No Reject/No Eject outlined in the LOD 69-1, the State developed a MCO reporting template (CISC Report Template). Attached is D11 - IT 6.1 - CISC Reporting Template.Exhibit 1.xlsx

The report template breaks out the required No Reject/No Eject elements as described in the LOD, including the following:

**Provider Training Tab:** MCOs are required to amend provider contracts to include the No Reject/No Eject provision. If an MCO determines a provider is not accepting, or prematurely discharging, a CISC the MCO must provide training and/or education.

- Number of amended provider contracts that include the no reject, no eject provision;
- Percentage of amended provider contracts completed;
- Number of individual providers trained or educated if out of compliance with the no reject, no eject provision;

**Member NE/NR Tab:** MCOs will be required to report the following for CISCs:

- Number of prior authorizations approved or denied;
- Number of CISCs with services either reduced or modified;
- Number of CISCs with services delayed or not approved within 10 days;
- Number of discharges; and
- Number of notices of adverse actions. MCOs send notices of adverse actions when a service is denied, reduced, or modified.

**NE/NR Detail Tab:** MCOs will be required to report if a discharge was safe or unsafe, detailed information and MCO assessment about provider training, education or corrective actions taken.

The template will be issued to the MCOs who will begin reporting to the State on a quarterly basis who will utilize the information on the reporting template to ensure the MCOs are in compliance with the no reject, no eject provision.

Additionally, HSD and CYFD will conduct the following activities related to this deliverable within 45-60 days of co-neutral approval:

1. Add no reject/no eject requirements to the NM Wraparound CARES provider manual/implementation plan (Completed);
2. Include no reject/no eject requirements in the HFW training (Completed);
3. add no reject/no eject requirements to CCSS audit tool;
4. Add no reject/no eject to quality compliance tool;
5. The no reject/no eject trainings will be incorporated into the NM Wraparound CARES provider manual/implementation plan. The MCOs will use updated the

NM Wraparound CARES provider manual/implementation plan as the basis for developing training for providers (Completed);
6. CYFD and HSD will develop shared standards to track denial of services to CISC in congregate care settings; and
7. CYFD and HSD will develop a process for conducting random sampling of instances of reject or eject (Completed).

## Identification & Removal of Administrative Barriers for BH Providers

HSD's Behavioral Health Services Division partnered with the Behavioral Health Provider's Association in 2019 to begin the process to address administrative barriers identified by the association. Barriers include MCO claims payment issues and the contracting and credentialing processes for BH providers with Medicaid and the Managed Care Organizations. The State partnered with the provider association to first address claims payment issues by creating various pilot groups of providers who identified members for which they were experiencing claims payment issues. The providers submitted spreadsheets with unpaid claims that were provided to the MCOs for research and resolution.

Frequent claim denial reasons included but are not limited to: Duplicate claim; patient not eligible; timely filing has expired; and no prior authorization received. As a result, the MCOs researched and presented resolutions for identified barriers. The MCOs implemented the following modifications as a result of their research:

- MCOs updated edits within their systems to prevent the denial of certain claims:
    - H0015 (Intensive Outpatient) - system updated to accept 4 units
    - H2015 (CCSS) - units and modifiers updated to resolve taxonomy issue
    - H2017(PSR) - set to appropriately deny claims for members under age 18
    - Corrected a number of E&M codes that were being denied by one MCO
    - Corrected system to address denials of FQHC claims
- MCOs conducted refresher training for their provider services teams regarding linking fee schedules to newly added providers and how to update a member's primary insurance information;
- MCOs educated providers on MCO claims resolution processes, including the appropriate provider types that should be utilized when submitting claims; and
- MCO removal of Explanation of Benefits (EOB) denial requirements for certain billing codes.

    - HSD issued MCO D12 - IT 6.1 - LOD-67-EOB-Exception-for-Behavioral-Health-Services-and-Providers.pdf to provide the MCOs clarification regarding EOB exceptions for BH Services and Providers.

https://www.hsd.state.nm.us/lookingforinformation/centennial-care-letters-of-direction/

Additionally, in an effort to reduce provider administrative burden with respect to the contracting and credentialing of providers with HSD and the MCOs, the State requested, during a second phase of the BH Provider Association and State workgroups, each MCO to provide a workbook with all BH providers who had been credentialed over a six-month period subsequent to the workgroup's initial meeting. As a result of this submission, a random sample of credentialed provider applications during that six-month timeframe indicates that the average turnaround times for the MCOs credentialing processes were: Blue Cross Blue Shield NM (BCBSNM) - 13 days; Presbyterian Health Plan (PHP) - 11 days; and Western Sky Community Care (WSCC) - 21 days.

The only data available to the group from prior to that workflow development came from providers who submitted qualitative data. A few example cases indicated that BH credentialing was taking in excess of 30 days at times. Centennial Care contracts require credentialing within a 30-calendar day period.

Lastly, the HSD's Medicaid Management Information System Replacement (MMISR) project rollout includes a Business Management System module that will include provider enrollment and management. This module will:

- Provide business services that are flexible, configurable, meet federal requirements for initial and ongoing screening and enrollment;
- Work with provider associations, universities, and MCOs to address provider gaps by region, provider type, and capacity;
- Provide support, education, communication, and assistance;
- Conduct outreach to unenrolled and non-participating providers;
- Simplify and streamline enrollment processes;
- Automate validation of provider certification and licensure;
- Automate and enhance provider communication;
- Implement early detection of providers who have issues and provide technical assistance;
- Establish a single enrollment process by consolidating multiple provider enrollment applications and processes that are currently maintained separately; and
- Collaborate with Systems Integration (SI), Unified Portal (UP) and other modules to streamline services and ease access for providers.

The implementation date for this MMISR module is scheduled for May 2024.

## Exhibits:

D11 - IT 6.1 - CISC Reporting Template.Exhibit 1.xlsx
D12 - IT 6.1 - LOD-67-EOB-Exception-for-Behavioral-Health-Services-and-Providers.pdf

D9 - IT 5.1 - MCO LOC 69-1 Requirements for CISC.pdf