western sky community care™

Provider Manual

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WELCOME

Welcome to Western Sky Community Care! Thank you for being part of our network of healthcare professionals. We look forward to working with you to improve the health of our communities, one person at a time.

About Us

Established to deliver quality healthcare in the state of New Mexico through local, regional and community-based resources, Western Sky Community Care is a Managed Care Organization and subsidiary of Centene Corporation (Centene). Western Sky Community Care exists to improve the health of its beneficiaries through focused, compassionate and coordinated care. Our approach is based on the core belief that quality healthcare is best delivered locally.

About this Manual

The Provider Manual contains comprehensive information about Western Sky Community Care operations, benefits, policies, and procedures. The most up-to-date version can be viewed from the "For Providers" section of our website https://www.westernskycommunitycare.com//. You will be notified of updates via notices posted on our website and/or in Explanation of Payment (EOP) notices. To obtain a hard copy of this manual, please contact Provider Services at the number provided in the Key Contacts section of this manual.

Billing guidelines and information can be found in the Western Sky Community Care Provider Billing Manual, located in the "For Providers" section of our website https://www.westernskycommunitycare.com//. The Provider Billing Manual includes information on:

- Encounter data submission guidelines
- Claims submission protocols and standards,
- Instructions/information necessary for Clean Claims
- Payment policies

About Centennial Care 2.0

Centennial Care is the Medicaid program of the State of New Mexico. It was founded in 2014 and services were provided to eligibile members by various Managed Care Organizations (MCOs). In 2017 the Humans Services Department, Medical Assistance Division solicited feedback on Centennial Care as they developed Centennial Care 2.0. Centennial Care 2.0 launched on January 1, 2019.

Centennial Care 2.0 aims to improve over the original Centennial Care program with enhanced care coordination in order to ensure that members with complex conditions and medical needs receive the care they need, especially during transitions between care settings. It also expands members' access to long term services and support, as well as better integrating care between physical and behavioral health providers. Centennial Care 2.0 aims to help its beneficiaries actively participate in their own health care, leading to lower overall costs of care, without compromising quality or clinical outcomes.

Populations Served

Please refer to the Populations Served section on page 9 of this manual for a complete list of the member populations who are eligible for coverage under the Centennial Care 2.0 program.

Health Risk Assessment (HRA)

All Centennial Care 2.0 beneficiares will be given a complete Health Risk Assessment (HRA) in order to identify care gaps or other needed interventions. For more information on the nature and timing of the HRA process, please see the Health Risk Assessment paragraph in the Care Coordination section of this manual, found on page 55 of this manual.

Enrollment

For information on enrollment, exemptions, and PCP assignment for enrolled members, please refer to the following sections: Populations Served on pages 9-10, and PCP Assignment on page 28.

KEY CONTACTS

The following chart includes several important telephone and fax numbers available to your office. When calling Western Sky Community Care, please have the following information available:

- NPI (National Provider Identifier) number
- Tax ID Number (TIN)
- Member's Western Sky Community Care ID number or Medicaid ID number

Department	Telephone Number	Fax Number
Provider Services	844-738-5019 TTY: 711	844-853-2480
Member Services	844-543-8996 TTY: 711	844-320-2479
Prior Authorization Request	844-831-7024 TTY: 711	844-805-4593
Concurrent Review	844-831-7024 TTY: 711	844-751-9314
Behavioral Health Prior Authorization/Concurrent Review	844-831-7024	844-618-9572
Care Management	844-543-8996 TTY: 711	844-583-2214
Envolve Dental	844-732-3046 TTY: 711	N/A
Envolve Vision	844-833-1905 TTY: 711	N/A
24 Hour Nurse Advice Line (24/7 Availability)	844-543-8996 TTY: 711	
Centennial Care Provider Service Center	1-888-997-2583	

Acaria	1-855-535-1815	855-217-0926
Centennial Care MCO Plan Enrollment	1-888-997-2583	
Adult Protective Services Abuse Hotline – 24 hours a day	866-654-3219 or 505-476-4912	
Paper Claims Submission	Claim Appeals	Medical Necessity Appeal
Western Sky Community Care Attn: Claims PO Box 8010 Farmington, MO 63640-8010	Western Sky Community Care Attn: Claim Appeals PO Box 8010 Farmington, MO 63640-8010	Western Sky Community Care Attn: Medical Necessity Appeals 5300 Homestead Rd NE Albuquerque, NM 87110
Electronic Claims Submission		
Western Sky Community Care c/o Centene EDI payor ID: 68069 1-800-225-2573, ext. 6075525 or by e-mail to: EDIBA@centene.com		

POPULATIONS SERVED

The following populations are served by the Centennial Care 2.0 program:

- TANF
- CHIP
- Adoption Assistance and Foster Care Children
- SSI/ABD, including duals
- IDD and Medically Fragile (for Acute Care Services Only)

The following populations are exempt from mandatory enrollment

- Individuals who are Native American and not in need of LTSS
- Individuals residing in ICF/IDD facility
- Qualified Medicare Beneficiary (QMB) and Specified Low Income Medicare Beneficiary (SLMB)
- Program for All Inclusive Care for the Elderly (PACE)
- Individuals covered only under Medicaid Family Planning
- Individuals under Emergency Medical Services for Aliens (EMSA) program

VERIFYING ELIGIBILITY

Western Sky Community Care Providers should verify Member eligibility before every service is rendered, using one of the following methods:

1. **Log on to our Secure Provider Web Portal** at https://www.westernskycommunitycare.com//. Using our secure Provider Portal, you can check Member eligibility. You can search by date of service and either of the following: Member name and date of birth, or Member Medicaid ID and date of birth.
2. **Call our automated member eligibility IVR system.** Call 844-853-2480 from any touch-tone phone and follow the appropriate menu options to reach our automated Member eligibility-verification system 24 hours a day. The automated system will prompt you to enter the Member Medicaid ID and the month of service to check eligibility.
3. **Call Western Sky Community Care Provider Services.** If you cannot confirm a Member's eligibility using the methods above, call our toll-free number at 844-853-2480. Follow the menu prompts to speak to a Provider Services Representative to verify eligibility prior to rendering services. Provider Services will need the Member name, Member Medicaid ID, and Member date of birth to check eligibility.

Through Western Sky Community Care's Secure Provider Portal, PCPs are able to access a list of eligible Members who have selected their services or were assigned to them. The Patient List is reflective of all demographic changes made within the last 24 hours. The list also provides other important information, including indicators for patients whose claims data show a gap in care, such as an adult BMI assessment. To view this list, log on to https://www.westernskycommunitycare.com//.

Eligibility changes can occur throughout the month and the Patient List does not prove eligibility for benefits or guarantee coverage. Use one of the above methods to verify Member eligibility on the date of service.

All new Western Sky Community Care Members receive a Western Sky Community Care Member ID card. Members will keep their state issued ID card to receive services not covered by the plan. A new card is issued only when the information on the card changes, if a Member loses a card, or if a Member requests an additional card.

Possession of a Member ID card is not a guarantee of eligibility. Use one of the above methods to verify Member eligibility on the date of service.

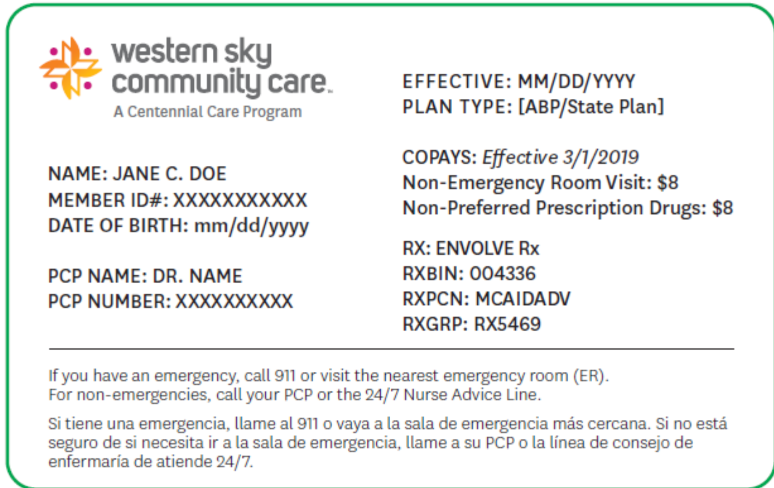
Member Identification Card

Whenever possible, Members should present both their Western Sky Community Care Member ID card and a photo ID each time services are rendered by a Provider. If you are not familiar with the person seeking care as a Member of our Health Plan, please ask to see photo identification.

If you suspect fraud, please contact Provider Services at 844-853-2480 immediately.

Members must also keep their state-issued Medicaid ID card in order to receive benefits that are not covered by Western Sky Community Care.

Sample (front & back):



IMPORTANT CONTACT INFORMATION/INFORMACIÓN IMPORTANTE DE CONTACTO

MEMBERS/MIEMBROS: Call **1-844-543-8996** TTY/TDD: **711**
For: **Member Services**/Servicios para los miembros
24/7 Nurse Advice Line/Línea de consejo de enfermería 24/7
Prescription Drugs/Medicamentos con receta

PROVIDERS/PROVEEDORES:
Eligibility: **1-844-738-5019 (TTY: 711)**
Prior Authorization: **1-844-831-7024**
Medical Claims: **Western Sky Community Care PO Box 8010, Farmington, MO 63640**
Provider/claims information via the web: **WesternSkyCommunityCare.com**
Pharmacy Help Desk/Mesa de ayuda de farmacia: **1-844-212-8505**
Dental: **1-844-732-3046**
Vision: **1-844-833-1905**

Note: Some services may require prior authorization from your physician.
Such services are funded in part with the state of New Mexico.

Co-payment Verification

Some Western Sky Community Care members are subject to a co-payments for certain services, which are tracked by Western Sky Community Care. This will be indicated on their ID card. Member co-payments are capped at 5% of household income, and may not be collected after members have paid reached that amount. Prior to collecting co-payments from any member, and in conjunction with eligibility verification, providers should verify a member's co-payment status before collecting any co-payments.

Online Resources

Our website can significantly reduce the number of telephone calls providers need to make to the health plan. The website allows 24/7 immediate access to current Provider and Member information.

Please contact your Provider Relations Representative or our Provider Services department at 844-738-5019 with any questions or concerns regarding the website.

Western Sky Community Care website is located at https://www.westernskycommunitycare.com//. Providers can find the following information on the website:

- Prior Authorization List
- Applicable Forms
- Western Sky Community Care Plan News
- Clinical Guidelines
- Provider Bulletins
- Information on Disability Access
- Contract Request Forms
- Provider Network Specialist Contact Information
- Provider Training Manual
- Provider Education Training Schedule

SECURE WEBSITE

The Western Sky Community Care Secure Provider Web Portal allows Providers to check Member eligibility and benefits, submit and check status of claims, request authorizations and send messages to communicate with Western Sky Community Care staff. All Providers and designated office staff have the opportunity to register for the secure Provider website in just 4 easy steps. Upon registration, tools are available that make obtaining and sharing information easy! It's simple and secure!

Go to https://www.westernskycommunitycare.com// to register. On the home page, select the Login link on the top right to start the registration process. Please contact a Provider Relations Representative for a tutorial on the Secure Provider Web Portal.

Functionality

Through the Secure Provider Web Portal, you can:

- Check Member eligibility
- View Member health records
- View the PCP panel (patient list)
- View and submit claims and adjustments
- Verify claim status
- Verify proper coding guidelines
- View payment history
- View and submit authorizations
- Check authorization requirements
- Verify authorization status
- View Member gaps in care
- Contact us securely and confidentially
- Add/Remove account users
- Determine payment/check clear dates
- Add/Remove TINs from a user account
- View PCP Quality Incentive Report
- View and print Explanation of Payment (EoP)

Secure Portal Disclaimer

Providers agree that all health information, **including that related to** patient conditions, medical utilization and pharmacy utilization, available through the portal or any other means, will be used exclusively for patient care **and other related purposes as permitted by the HIPAA Privacy Rule.**

GUIDELINES FOR PROVIDERS

Medical Home Model

Western Sky Community Care is committed to supporting its network Providers in achieving recognition as Medical Homes and will promote and facilitate the capacity of primary care practices to function as Medical Homes by using systematic, patient-centered and coordinated Care Management processes.

Western Sky Community Care will support Providers in obtaining either NCQA's Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or the Joint Commission's Primary Care Medical Home Option for Ambulatory Care accreditation.

The purpose of the Medical Home program is to promote and facilitate a Medical Home model of care that will provide better healthcare quality, improve self-management by Members of their own care and reduce avoidable costs over time. Western Sky Community Care will actively partner with Providers, community organizations, and groups representing our Members to increase the numbers of Providers who are recognized as Medical Homes (or committed to becoming recognized).

Western Sky Community Care has dedicated resources to ensure its Providers achieve the highest level of Medical Home recognition with a technical support model that will include:

- Readiness survey of contracted Providers
- Education on the process of becoming certified
- Resources, tools, and best practices

The Secure Provider Web Portal offers tools to help support PCMH accreditation elements. These tools include:

- Online care gap notification
- Member panel roster (including Member detail information)

For more information on the Medical Home model or how to become a Medical Home, contact your Provider Relations Representative.

Referrals

Western Sky Community Care prefers that the PCP coordinates healthcare services. PCPs are encouraged to refer a Member to another Provider when medically-necessary care is needed that is beyond the scope of what the PCP can provide. Obtaining referrals from the PCP are not required by Western Sky Community Care as a condition of payment for services.

The PCP must obtain prior authorization from Western Sky Community Care for referrals to certain Specialty Providers as noted on the prior authorization list. All out-of-network services require Prior Authorization as further described in this manual, except for family planning, emergency room, and table-top x-ray services. Providers are also required to promptly notify Western Sky Community Care when prenatal care is rendered.

Western Sky Community Care encourages Specialists to communicate to the PCP the need for a referral to another Specialist. This allows the PCP to better coordinate care and become aware of the additional service request.

Providers are prohibited from making referrals for designated health services to healthcare entities with which the Provider or a member of the Providers' family has a financial relationship.

Members with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Member, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide those specialty medical services consistent with the Member's disabling condition, chronic illness, or special healthcare needs in accordance with the PCP responsibilities included in this manual. To initiate a PCP change to a Specialist, Members should contact Western Sky Community Care Member Services at our toll-free number. The Health Plan will verify the change with the current PCP and the intended Specialist to be assigned as the PCP and coordinated the PCP change.

Members will work with their Care Coordinators to arranged the services listed below. Billing for these services requires a prior-authorization:

- Behavioral support consulation
- Customized community support
- Emergency response
- Employment supports
- Environmental modifications ($5,000 limit every 5 years)
- Home health aide
- Self-directed personal care (formerly homemaker)
- Nutritional counseling
- Private duty nursing for adults
- Related goods (annual limits may apply)
- Respite (annual limits may apply)
- Skilled Maintenance therapy services
- Specialized therapies (annual limits may apply)
- Transporation (non-medical) (annual limits may apply)

Provider Accessibility Initiative

Western Sky is committed to providing equal access to quality health care and services that are physically and programmatically accessible for our members with disabilities. In May of 2017, our parent company,

Centene, launched a Provider Accessibility Initiative (PAI) to increase the percentage of Centene's providers that meet minimum federal and state disability access standards. One of the goals of the PAI is to improve the accuracy, completeness, and transparency of provider self-reported disability access data in Provider Directories so that members with disabilities have the most accurate, accessible, and up-to-date information possible related to a provider's disability access. To accomplish this, providers are asked to complete a self-report of disability access that will be verified by Western Sky through an onsite Accessibility Site Review (ASR).

- Western Sky's expectation, as communicated through the provider contract, is full compliance with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). "Minimum accessibility," as defined in the ASR Tool, is not to be confused with, nor is intended to replace, the obligation of full compliance with all federal and state disability access laws and regulations, which remains the legal responsibility of Western Sky providers.

Self-Referral

Members do not need a prior-authorization or referral for the following types of services when they are rendered by a Western Sky Community Care participating Provider:

- Behavioral support consulation
- Customized community support
- Emergency response
- Employment supports
- Environmental modifications ($5,00 limit every 5 years)
- Home health aide
- Self-directed personal care (formerly Homemaker)
- Nutritional counseling
- Private duty nursing for adults
- Related goods (annual limits may apply)
- Respite (annual limits may apply)
- Skilled Maintenance therapy services
- Specialized therapies (annual limits may apply)
- Transporation (non-medical) (annual limits may apply)

Non-Covered Services

Non-Covered services are services that are not covered by Western Sky Community Care. Members may be able to obtain Non-Covered Services under the Medicaid State Plan. Western Sky Community Care is responsible for informing Members about how to access Non-Covered Services, providing all required referrals, and assisting in the scheduling of these service. These services will be paid for by the State on a FFS basis. Please visit our website at https://www.westernskycommunitycare.com// or call Provider Services at 844-738-5019for a complete listing of these services.

Appointment Availability and Access Standards

Western Sky Community Care follows the accessibility requirements set forth by applicable regulatory and accrediting agencies. Western Sky Community Care monitors compliance with these standards on an annual basis and will use the results of appointment standards monitoring to ensure adequate appointment availability and reduce unnecessary emergency room utilization.

TYPE OF APPOINTMENT	SCHEDULING REQUIREMENT
Primary Care Providers, OB-GYN, Certified Nurse Midwives	Timeframe
Emergency Medical Condition	24 hours a day, 7 days a week
Urgent Medical Condition	Within 24 hours
Non-Urgent Sick Visits	Within 14 days, unless member requested
Routine Appointments	Within 30 days, unless member requested

Western Sky Community Care offers a comprehensive network of PCPs, Specialty Physicians, Hospitals, Diagnostic, and Ancillary Service Providers to ensure every Member has access to covered services. Below are the travel distance and access standards that Western Sky Community Care utilizes to monitor network adequacy:

Specialty	Access Requirement
Dental – Routine/Preventive	Within 60 days, unless member requested
Dental – Non-urgent/sick	Within 14 days, unless member requested
Dental – Urgent	Within 24 hours
Behavioral Health – Non-urgent	Within 14 calendar days, unless member requested
Behavioral Health – Urgent	Within 24 hours
Behavioral Health – Crisis	Face to face appointment within 2 hours
Specialty Outpatient (other than Behavioral Health)	Within 21 days, unless member requested
Labs, Imaging, and other testing – Walk-ins	Wait times should be consistent with severity of clinical need
Labs, Imaging, and other testing – Appointments	Within 48 hours, according to severity of clinical need
Pharmacy – In-Person Fill Time	Within 40 minutes

Specialty	Access Requirement
Pharmacy – Provider Submitted	Within 90 minutes

Covering Providers

PCPs and Specialty Physicians must arrange for coverage with another Provider during scheduled or unscheduled time off, preferably with another Western Sky Community Care network Provider. In the event of unscheduled time off, please notify Provider Services department of coverage arrangements as soon as possible. The covering physician is compensated in accordance with the fee schedule in their agreement, and, if not a Western Sky Community Care network Provider, he/she will be paid as a non-participating Provider.

Telephone Arrangements

PCPs, Specialists, and Providers must:

- Answer the Member's telephone inquiries on a timely basis
- Prioritize appointments
- Schedule a series of appointments and follow-up appointments as needed by a Member
- Identify and, when possible, reschedule broken and no-show appointments
- Identify special Member needs while scheduling an appointment (e.g., wheelchair and interpretive linguistic needs, non-compliant individuals, or those with cognitive impairments)
- Adhere to the following response time for telephone call-back waiting times:
  - After-hours telephone care for non-emergent, symptomatic issues within 30 minutes
  - Same day for non-symptomatic concerns
- Schedule continuous availability and accessibility of professional, allied, and supportive personnel to provide covered services within normal working hours. Protocols shall be in place to provide coverage in the event of a Provider's absence
- After-hour calls should be documented in a written format in either an after-hour call log or some other method, and then transferred to the Member's medical record

Western Sky Community Care will monitor appointment and after-hours availability on an on-going basis through its Quality Improvement Program (QIP).

24-Hour Access

Western Sky Community Care PCPs and Specialty Physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to Members as needed 24 hours a day, 365 days a year as follows:

- A Provider's office phone must be answered during normal business hours
- During after-hours, a Provider must have arrangements for one of the following:
    - Access to a covering physician
    - An answering service
    - Triage service
    - A voice message that provides a second phone number that is answered
    - Any recorded message must be provided in English and Spanish, if the Provider's practice includes a high population of Spanish speaking Members

Examples of unacceptable after-hours coverage include, but are not limited to:

- The Provider's office telephone number is only answered during office hours
- The Provider's office telephone is answered after-hours by a recording that tells patients to leave a message
- The Provider's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed
- A Clinician returning after-hours calls outside 30 minutes

The selected method of 24-hour coverage chosen by the Member must connect the caller to someone who can render a clinical decision or reach the PCP or Specialist for a clinical decision. Whenever possible, the PCP, Specialty Physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number.

Western Sky Community Care will monitor Providers' offices after-hour coverage through surveys and through mystery shopper calls conducted by Western Sky Community Care Provider Network staff.

Confidentiality Requirements

Providers must comply with all federal, state, and local laws and regulations governing the confidentiality of medical information. This includes all laws and regulations pertaining to, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and applicable contractual requirements. Providers are also contractually required to safeguard and maintain the confidentiality of data that addresses medical records and confidential Provider and Member information, whether oral or written, in any form or medium. The following information is considered confidential:

All "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The privacy rule calls this information protected health information (PHI). "Individually identifiable health information," including demographic data, is information that relates to:

- The individual's past, present or future physical or mental health or condition
- The provision of health care to the individual
- The past, present, or future payment for the provision of healthcare to the individual

- Information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual
- Many common identifiers (e.g. name, address, birth date, social security number)

The privacy rule excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the family educational rights and privacy act, 20 u.s.c. § 1232g.

Provider offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Western Sky Community Care.

Release of data to third parties requires advance written approval from the Department of Human Services, except for releases of information for the purpose of individual care and coordination among providers, releases authorized by Members or releases required by court order, subpoena, or law.

Member Privacy Rights

Western Sky Community Care privacy policy assures that all Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state, and local laws and regulations, and applicable contractual requirements. Western Sky Community Care's privacy policy conforms with 45 c.f.r. (code of federal regulations): relevant sections of the HIPAA that provide Member privacy rights and place restrictions on uses and disclosures of protected health information (PHI) (§164.520, 522, 524, 526, and 528).

Western Sky Community Care's policy also assists our personnel and Providers in meeting the privacy requirements of HIPAA when Members or authorized representatives exercise privacy rights through privacy request including:

Use and Disclosure Guidelines

Western Sky Community Care is required to use and disclose only the minimum amount of information necessary to accommodate the request or carry out the intended purpose.

Limitations

A privacy request may be subject to specific limitations or restrictions as required by law. Western Sky Community Care may deny a privacy request under any of the following conditions:

- Western Sky Community Care does not maintain the records containing the PHI
- The requester is not the Member and we're unable to verify his/her identity or authority to act as the Member's authorized representative
- The documents requested are not part of the designated record set (e.g., credentialing information)
- Access to the information may endanger the life or physical safety of or otherwise cause harm to the Member or another person
- Western Sky Community Care is not required by law to honor the particular request (e.g., accounting for certain disclosures)

- Accommodating the request would place excessive demands on us or our time and resources and is not contrary to HIPAA

Cultural Competency

Cultural Competency within Western Sky Community Care is defined as the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population. It is the use of a systems perspective which values differences and is responsive to diversity at all levels in an organization. Cultural Competency is developmental, community focused, and family oriented.

In particular, it is the promotion of quality services to understand racial/ethnic groups through the valuing of differences and integration of cultural attitudes, beliefs and practices into diagnostic and treatment methods and throughout the system to support the delivery of culturally relevant and competent care. It is also the development and continued promotion of skills and practices important in clinical practice, cross-cultural interactions, and systems practices among providers and staff to ensure that services are delivered in a culturally competent manner.

Western Sky Community Care will ensure that inclusiveness and fairness are a part of all of our activities. We will be proactive in our efforts to extend our services and programs to our Limited English Proficiency (LEP) Members.

Western Sky Community Care will ensure compliance with the following statues and regulations to ensure eligible Members have equal access to quality health care regardless of their race, color, creed, national origin, religion, disability, or age: Title VI of the Civil Rights Act of 1964 (which prohibits discrimination on the basis of race, color and national origin); Section 504 of the Rehabilitation Act of 1973 (which prohibits discrimination on the basis of disability); and The Age discrimination of 1975 (which prohibits discrimination on the basis of age).

All subcontracts with providers of health care will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964.

Evidences of coverage for all lines of business will include a non-discrimination provision, which incorporates the requirements of the Civil Rights Act of 1964. Western Sky Community Care is committed to the development, strengthening, and sustaining of healthy Provider/Member relationships. Members are entitled to dignified, appropriate, and quality care. When healthcare services are delivered without regard for cultural differences, Members are at risk for sub-optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process. Providers should note that the experience of a Member begins at the front door. Failure to use Culturally Competent and linguistically competent practices could result in the following:

- Feelings of being insulted or treated rudely
- Reluctance and fear of making future contact with the office
- Confusion and misunderstanding
- Treatment non-compliance

- Feelings of being uncared for, looked down on, and devalued
- Parents resisting to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Misdiagnosis due to lack of information sharing
- Wasted time
- Increased grievances or complaints

Western Sky Community Care will evaluate the Cultural Competency level of its network Providers and provide access to training and tool kits to assist providers in developing Culturally Competent and culturally proficient practices. Network Providers must ensure:

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. Members or their representatives may request an interpreter be assigned to accompany them to any covered service. When the Member has identified the need to have an interpreter accompany them to their appointment, the Western Sky Community Care Member Services Representative can make the arrangements for the Member with the designee vendor. Recipients or their representatives can contact Member Services for a list of translation vendors in their area. Member Services can access the use of the Language Services, TDD telephone line or the hearing-impaired relay service to assist in this matter.
- Medical care is provided with consideration of the Member's race/ethnicity and language and its impact/influence on the Member's health or illness.
- Office staff that routinely interact with Members have access to and participate in Cultural Competency training and development.
- Office staff responsible for data collection make reasonable attempts to collect race and language information from the Member. Staff will also explain race/ethnicity categories to a Member so that the Member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed with consideration of the Member's race, country of origin, native language, social class, religion, mental and physical abilities, heritage, culture, age, gender, sexual orientation, and other characteristics that may influence the Member's perspective on healthcare.
- Office sites have posted and printed materials in English and Spanish, and other prevalent non-English languages required by the New Mexico Human Services Department.

The road to developing a Culturally Competent practice begins with the recognition and acceptance of the value of meeting the needs of the patients. Western Sky Community Care is committed to helping each Provider reach this goal. The following questions should be considered as care is provided to Western Sky Community Care Members:

- What are your own cultural values and identity?
- How do or can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?
- Do you embrace differences as allies in your patients' healing process?

The U.S. Department of Health and Human Services' Office of Minority Health has published a suite of online educational programs to advance health equity at every point of contact through development and promotion of culturally and linguistically appropriate services. Visit Think Cultural Health at www.thinkculturalhealth.hhs.gov to access these free online resources.

Americans with Disabilities Act (ADA)

Title III of the ADA mandates that public accommodations, such as a Provider's office, be accessible to those with disabilities. The provisions of the ADA protect qualified individuals with a disability from:

- Exclusion from participation in the benefits of services, programs or activities of a public entity.
- Denial of the benefits of services, programs or activities of a public entity.

Discrimination by any such entity. Western Sky providers must provide physical access, accommodations, and accessible equipment for members with physical or mental disabilities as required by 42 CFR Section 438.206(c)(3).

Providers are required to comply with all federal and state disability access laws and regulations (including, but not limited to, the Medicaid/CHIP Managed Care final rule provisions noted above, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and Section 1557 of the Affordable Care Act). Western Sky Community Care must inspect the office of any Provider who provides services on-site at the Provider's location and who seeks to participate in the Provider Network to determine whether the office is architecturally and programmatically accessible to persons with disabilities. Physical access," also referred to as "architectural access," refers to a person with a disability's ability to access buildings, structures, and the environment. "Programmatic access" refers to a person with a disability's ability to access goods, services, activities and equipment.

If any disability access barriers are identified, the provider agrees, in writing, to remove the barrier to make the office,facility, or services accessible to persons with disabilities within one hundred eighty (180) days after Western Sky Community Care has identified the barrier.

Providers are also required to:

- Provide Interpretation Services in all languages, including American and Mexican Sign Language, at all key points of contact through a variety of formats, including but not limited to: an in-person interpreter upon a member's request; telephone, relay, or video remote interpreting 24 hours a day seven days a week; or through other formats, such as real-time captioning or augmentative & alternative communication devices, that ensure effective communication.

- Provide Member-Informing Materials (print documents, signage, and multimedia materials such as websites) translated into the currently identified threshold or concentration standard languages, and provided through a variety of other means. This may include but not be limited to: oral interpretation for other languages upon request; accessible formats (e.g. documents in Braille, large print, audio format, or websites with captioned videos and/or ASL versions) upon request; and easy-to-understand materials provided in a manner that takes into account different levels of health literacy.
- Provide Reasonable Accommodations that facilitate access for Members. This includes but is not limited to accessible: medical care facilities, diagnostic equipment, and examination tables & scales; and modification of policies, practices, and procedures (e.g. modify policies to permit the use of service animals or to minimize distractions and stimuli for Members with mental health or developmental disabilities).
- Inform Members of the availability of these cultural, linguistic, and disability access services at no cost to Members on brochures, newsletters, outreach and marketing materials, other materials that are routinely disseminated to Members, and at Member orientation sessions and sites where Members receive covered services.
    - WSCC and participating providers shall also facilitate access to these services, and document a request and/or refusal of services in CRM or the provider's member data system.

Call your Provider Relations Representative at 844-738-5019 for more information.

Reporting Suspected Abuse and Neglect

All Western Sky Community Care Providers and their employees and administrators of a facility are mandatory reporters of suspected physical and/or sexual abuse and neglect of Western Sky Community Care Members. This requirement is further detailed under the Older Adult Protective Services Act and the Adult Protective Service Act. These laws have been established in order to detect, prevent, reduce, and eliminate, abuse, neglect, exploitation and abandonment of adults in need including Western Sky Community Care Western Sky Community Cares Members. If you suspect elder abuse or the abuse of an adult with a disability call Adult Protective Services at 1-800-490-8505, available 24 hours a day.

Abuse is defined by PA Code 15.2 as one or more of the following acts: a) the infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish b) the willful deprivation by a caretaker of goods or services necessary to maintain physical or mental health c) sexual harassment, rape, or abuse. Sexual abuse of a member is defined as intentionally, knowingly, or recklessly causing or attempting to cause the rape of, involuntary sexual intercourse with, sexual assault of, statutory sexual assault of, aggravated indecent assault of, indecent assault of, or incest with a Member.

Neglect is the failure to provide for oneself or the failure of a caretaker to provide goods or services essential to avoid a clear and serious threat to physical or mental health.

Common Signs of Abuse:

- Bruises or broken bones

- Weight loss
- Memory loss
- Personality changes
- Social isolation
- Changes in banking habits
- Giving away assets such as money, property, etc.

For further information, please refer to the DHS website at http://dhs.pa.gov/.

Mainstreaming

Western Sky Community Care considers mainstreaming of its Western Sky Community Cares Members an important component of the delivery of care and expects participating Providers to treat Members without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, gender identity, sexual preference, language, MA status, disease or pre-existing condition, health status, income status, program membership or physical or behavioral disabilities, except where medically indicated. Examples of prohibited practices are:

- Denying a Member a covered service or availability of a facility
- Providing a Western Sky Community Care Member a covered service that is different or in a different manner, or at a different time or at a different location than to other “public” or private pay patients (examples: different waiting rooms or appointment times or days)

Advance Directives

The Patient Self-Determination Act of 1990, effective December 1, 1991, requires health professionals and facilities serving those covered by Medicare and Medicaid to give adult Members written information about the Members' right to have an Advance Directive. An Advance Directive is a legal document through which a Member may provide directions or express preferences concerning his or her medical care and/or to appoint someone to act on his or her behalf. Members can use Advance Directives when the Member is unable to make or communicate decisions about his or her medical treatment. Advance Directives are prepared before any condition or circumstance occurs that causes the Member to be unable to actively make a decision about his or her medical care.

There are two types of Advance Directives:

- Living will or health care instructions
- Appointment of a Health Care Power of Attorney

Western Sky Community Care is committed to ensure that Members are aware of and are able to avail themselves of their rights to execute Advance Directives. Western Sky Community Care is equally committed to ensuring that its Providers and staff are aware of, and comply with, their responsibilities under federal and state law regarding Advance Directives.

Western Sky Community Care Care Coordinators and Care Management staff will provide and/or ensure that network practitioners are providing written information to all adult Members receiving medical care with respect to their rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives. Advance Directives are addressed by the treating physician with the Member during an office visit. Neither Western Sky Community Care or Providers will condition the authorization or provision of care or otherwise discriminate against a Member based on whether or not the Member has executed an Advance Directive. Western Sky Community Care will facilitate communications between a Member or Member's representative and the Member's Provider if/when the need is identified to ensure that they are involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.

Western Sky Community Care is aligned with the HEDIS Care of Older Adults measure, which includes annual review of advanced care planning, medication review, functional status, and pain assessment. To do this, Western Sky Community Care will annually assess and document the Advance Directive status in the Case Management systems.

PCPs and Providers delivering care to Western Sky Community Care Members must ensure adult members receive information on Advance Directives and are informed of their right to execute Advance Directives. Providers must document such information in the permanent medical record.

Western Sky Community Care recommends to its PCPs and physicians that:

- The first point of contact for the Member in the PCP's office should ask if the Member has executed an Advance Directive and the Member's response should be documented in the medical record.
- If the Member has executed an Advance Directive, the first point of contact should ask the Member to bring a copy of the Advance Directive to the PCP's office and document this request in the Member's medical record.
- An Advance Directive should be a part of the Member's medical record and include mental health directives.

If an Advance Directive exists, the physician should discuss potential medical emergencies with the Member and/or designated family member/significant other (if named in the Advance Directive and if available) and with the referring physician, if applicable. Any such discussion should be documented in the medical record.

Provider Responsibility

Providers must comply with federal and state laws regarding Advance Directives (also known as health care power of attorney and living wills). Providers must also comply with contractual requirements for adult Members. Western Sky Community Care requires that Providers obtain and maintain Advance Directive information in the Member's medical record. Requirements for Providers include:

- Maintaining written policies that address a Member's right to make decisions about their medical care, including the right to refuse care.
- Providing Members with written information about Advance Directives.

- Documenting the Member's Advance Directives, or lack of, in his or her medical record.
- Communicating the Member's wishes to attending staff in hospitals or other facilities.
- Not discriminating against a Member or making treatment conditional on the basis of his or her decision to have or not have an Advance Directive.
- Providing staff education on issues related to Advance Directives.

Members can file complaints or grievances concerning noncompliance with Advance Directive requirements with Western Sky Community Care and/or with the New Mexico DHS. Western Sky Community Care provides information about Advance Directives to Members in the Member Handbook, including the Member's right to make decisions about their medical care, how to obtain assistance in completing or filing a living will or health care power of attorney, and general instructions.

For more information or to communicate complaints regarding noncompliance with Advance Directive requirements, contact:

NM Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
Constituent Services: 1-505-827-6287

http://www.hsd.state.nm.us/default.aspx

Primary Care Practitioner (PCP)

The Primary Care Practitioner (PCP) is a specific physician, physician group or a CRNP operating under the scope of his or her licensure, who is responsible for supervising, prescribing, and providing Primary Care Service; locating, coordinating and moninotring other medical care; rehabilitative service; and maintaining continuity of care on behalf of a Member. PCPs are the cornerstone of Western Sky Community Care service delivery model. The PCP serves as the "Medical Home" for the Member. The Medical Home concept assists in establishing a Member/Provider relationship, supports continuity of care, and patient safety. This leads to elimination of redundant services, cost effective care, and better health outcomes.

Western Sky Community Care offers a robust network of primary care Providers to ensure every Member has access to a Medical Home within the required travel distance standards (urban areas 2 within 30 minutes of each Member's home and rural 2 within 60 minutes of each Member's home).

Western Sky Community Care requires PCPs, dentists, and Specialists to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. An effort will be considered reasonable if it includes three (3) attempts to contact the Member. Attempts may include, but are not limited to: written attempts, telephone calls, and home visits. At least one (1) such attempt must be a follow-up telephone call.

Provider Types That May Serve As PCPs

PCP shall be a medical or behavioral health provider in our network but Western Sky Community Care may also designate others to be PCPs including:

- Family Practitioner
- Federally Qualified Health Center (FQHC)
- General Practitioner
- Internist
- Pediatrician
- Obstetrician or Gynecologist (OB/GYN)
- Rural Health Center (RHC)

Specialists as PCPs

Members with disabling conditions or chronic illnesses may request that their PCP be a Specialist. The designation of the Specialist as a PCP must be in consultation with the current PCP, Member, and the Specialist. The Specialist serving as a PCP must agree to provide or arrange for all primary care, including routine preventive care, and provide specialty medical services consistent with the member's disabling condition, chronic illness or special healthcare needs in accordance with the PCP responsibilities included in this manual.

Member Panel Capacity

All PCPs reserve the right to determine the number of Members they are willing to accept into their panel. Western Sky Community Care **does not** guarantee any Provider will receive a certain number of Members. The PCP to member ratio shall not exceed 1,000 Members to a single PCP.

PCPs interested in exceeding the Member limit should contact their Provider Relations Representative to discuss providing satisfactory evidence of added capacity by use of physician extenders and/or extended office hours to accommodate additional Members. This ratio applies to all MCOs.

If a PCP declares a specific capacity for his/her practice and wants to make a change to that capacity, the PCP must contact Western Sky Community Care Provider Services at 844-738-5019. A PCP shall not refuse to treat Members as long as the physician has not reached their requested panel size.

Providers shall notify Western Sky Community Care in writing at least 45 days in advance of his or her inability to accept additional Medicaid covered persons under Western Sky Community Care agreements. In no event shall any established patient who becomes a Western Sky Community Care Member be considered a new patient.

PCP Assignment

Western Sky Community Care Members have the freedom to choose a PCP from our comprehensive Provider network. Within 15 days of enrollment, Western Sky Community Care will send new Members a letter encouraging them to select a PCP. For those Members who have not selected a PCP during enrollment or within 30 calendar days of enrollment, Western Sky Community Care will use a PCP auto-assignment algorithm to assign an initial PCP. The algorithm assigns members to a PCP according to the following criteria:

1. Member's geographic location
2. Member's previous PCP, if known
3. Other family members' PCPs, if known
4. Special healthcare needs, including pregnancy, if known
5. Special language and cultural considerations, if known

Primary Care Practitioner (PCP) Responsibilities

Western Sky Community Care will monitor PCP actions for compliance with the following responsibilities. PCP responsibilities include, but are not limited to, the following:

- Providing primary and preventive care and acting as the Member's advocate
- Providing, recommending and arranging for care
- Providers are required to comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Documenting all care rendered in a complete and accurate encounter record that meets or exceeds the DHS data specifications
- Maintaining continuity of each Member's healthcare
- When needed, effectively communicating with the Member by using (free of charge to the Member):
    - Sign language interpreters for those who are deaf or hard of hearing
    - Oral interpreters for those individuals with LEP
- Making referrals for specialty care and other medically necessary services, both covered and non-covered by the plan
- Maintaining a current medical record for the Member, including documentation of all services provided to the Member by the PCP, as well as any specialty or referral services
- Arranging for Behavioral Health Services
- Allowing Western Sky Community Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs
- Ensuring coordination and continuity of care with Providers, including all Behavioral Health and Long-Term Care Providers, according to Western Sky Community Care policy; and
- Ensuring that the Member receives appropriate prevention services for the Member’s age group.
- Referring a Member for Behavioral Services based on the following indicators:
    - Suicidal/homicidal ideation or behavior;
    - At-risk of hospitalization due to a Behavioral Health condition;
    - Children or adolescents at imminent risk of out-of-home placement in a psychiatric acute care hospital or residential treatment facility;
    - Trauma victims;
    - Serious threat of physical or sexual abuse or risk to life or health due to impaired mental status and judgment, mental retardation, or other developmental disabilities;

- Request by Member or Representative for Behavioral Health services;
- Clinical status that suggests the need for Behavioral Health services;
- Identified psychosocial stressors and precipitants;
- Treatment compliance complicated by behavioral characteristics;
- Behavioral and psychiatric factors influencing medical condition;
- Victims or perpetrators of Abuse and/or neglect and Members suspected of being subject to Abuse and/or neglect;
- Non-medical management of substance abuse;
- Follow-up to medical detoxification;
- An initial PCP contact or routine physical examination indicates a substance abuse problem;
- A prenatal visit indicates substance abuse problems;
- Positive response to questions indicates substance abuse, observation of clinical indicators or laboratory values that indicate substance abuse;
- A pattern of inappropriate use of medical, surgical, trauma or emergency room services that could be related to substance abuse or other Behavioral Health conditions; and/or
- The persistence of serious functional impairment.

Specialist Responsibilities

Western Sky Community Care encourages Specialists to communicate to the PCP the need for a referral to another Specialist, rather than making such a referral themselves. This allows the PCP to better coordinate the Members' care and ensure the referred Specialty physician is a participating Provider within the Western Sky Community Care network and that the PCP is aware of the additional service request. The Specialty physician may order diagnostic tests without PCP involvement by following Western Sky Community Care referral guidelines.

Emergency admissions will require notification to Western Sky Community Care's Medical Management department within the standards set forth in the Utilization Management section of this manual. All non-emergency inpatient admissions require Prior Authorization from Western Sky Community Care.

The Specialist Provider must:

- Maintain contact with the PCP.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Obtain authorization from Western Sky Community Care Medical Management department if needed before providing services.
- Coordinate the Member's care with the PCP.
- Provide the PCP with consult reports and other appropriate records within five (5) business days.
- Be available for or provide on-call coverage through another source 24 hours a day for management of Member care.
- Maintain the confidentiality of medical information.
- Allow Western Sky Community Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

Western Sky Community Care Providers should refer to their contract for complete information regarding their obligations and mode of reimbursement. Such reimbursement shall be no less than the published Medicaid fee-for-service rate in effect on the date of service or its equivalent (such as a DRG case rate), unless mutually agreed to by both Western Sky Community Care and the Provider in the Provider contract.

The Western Sky Community Care requires PCPs, Dentists, and Specialists to conduct affirmative outreach whenever a Member misses an appointment and to document this in the medical record. Such an effort shall be deemed to be reasonable if it includes three (3) attempts to contact the Member. Such attempts may include, but are not limited to: written attempts, telephone calls and home visits. At least one (1) such attempt must be a follow-up telephone call.

Hospital Responsibilities

Western Sky Community Care utilizes a network of Hospitals to provide services to Western Sky Community Care Members. Hospital Services Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the RFP.

Hospitals must:

- Notify the PCP immediately or at most no later than the close of the next business day after the Member's emergency room visit.
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.

- Obtain authorizations for all inpatient and selected outpatient services as listed on the current prior authorization list, except for emergency stabilization services.
- Notify Western Sky Community Care Medical Management department by sending an electronic file of the ER admission within 24 hours or the next business day. The electronic file should include the Member's name, Medicaid ID, presenting symptoms/diagnosis, DOS, and Member's phone number.
- Notify Western Sky Community Care Medical Management department of all admission within one business day.
- Notify Western Sky Community Care Medical Management department of all newborn deliveries within two (2) business days of the delivery.
- Allow Western Sky Community Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs.

Long-Term Services and Supports Provider Responsibilities

The LTSS Provider is required to adhere to the following responsibilities:

- Provide Western Sky Community Care Members with a professionally recognized level of care and efficiency consistent with community standards, consistent with the Health Plan's clinical and non-clinical guidelines and within the practice of your professional license
- Abide by the terms of the Participating Provider Agreement
- Comply with all plan policies, procedures, rules and regulations, including those found in this manual
- Maintain confidential medical records consistent with Western Sky Community Care's medical records standards, medical record keeping guidelines, and applicable HIPAA regulations
- Maintain a facility that promotes member safety
- Comply with all federal and state disability access laws and regulations and provide physical and programmatic access to members with disabilities.
- Participate in Western Sky Community Care's quality improvement program initiatives
- Participate in Provider orientations and continuing education
- Abide by the ethical principles of your profession
- Notify the plan if you are undergoing an investigation, or agree to written orders by the state licensing agency
- Notify the plan if there is a change of status with Member eligibility
- Ensure you have staff coverage to maintain service delivery to Members
- Allow Western Sky Community Care direct access (not via vendor) to medical records for the

purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs

Voluntarily Leaving the Network

Providers must give Western Sky Community Care notice of voluntary termination following the terms of their participating agreement with our Health Plan. In order for a termination to be considered valid, Providers are required to send termination notices via certified mail (return receipt requested) or overnight courier. In addition, Providers must supply copies of medical records to the Member's new Provider upon request and facilitate the Member's transfer of care at no charge to Western Sky Community Care or the Member.

Western Sky Community Care will notify affected Members in writing of a Provider's termination, within 15 calendar days of the receipt of the termination notice from the Provider, provided that such notice from the Provider was timely.

Providers must give Western Sky Community Care 60 days prior written notice of voluntary termination following the terms of their participating agreement with our Health Plan.

BENEFIT EXPLANATIONS AND LIMITATIONS

Western Sky Community Care network Providers supply a variety of medical benefits and services, some of which are itemized on the following pages. For specific information not covered in this provider manual, please contact Provider Services at 844-738-5019.A Provider Service Representative will be happy to assist you.

Western Sky Community Care covers, at a minimum, those core benefits and services specified in our Agreement with the State of New Mexico Human Services Department Medicaid Managed Care Services.

Emergency Care Services

Western Sky Community Care defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Impairments of bodily functions, or
3. Significant disfigurement, or
4. Serious dysfunction of any bodily organ or part as per 42 CFR 438.114.(a)

Emergency Care Services must be accessible 24 hours a day, seven days a week. Emergency services are provided in a hospital or comparable facility in order to stabilize the member and to determine the severity of the condition and appropriate treatment of acute symptoms.

Members may access emergency services at any time without Prior Authorization or prior contact with Western Sky Community Care. Providers should inform Members that if they are unsure as to the urgency or emergency of the situation, they are encouraged to contact their Primary Care Practitioner (PCP) and/or Western Sky Community Care's 24 hour Nurse Advice Hotline for assistance; however, this is not a requirement to access emergency services. Western Sky Community Care contracts with emergency services Providers as well as non-emergency Providers who can address the Member's non-emergency care issues occurring after regular business hours or on weekends.

Emergency services are covered by Western Sky Community Care when furnished by a qualified Provider, including out-of-network Providers, and will be covered until the Member is stabilized. Any screening examination services conducted to determine whether an emergency medical condition exists will also be covered by Western Sky Community Care. Emergency services will cover and reimburse regardless of whether the Provider is in Western Sky Community Care's Provider network and will not deny payment for treatment obtained under either of the following circumstances:

1. A Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical Condition; or

2. A representative from the Plan instructs the member to seek emergency services

Once the Member's emergency medical condition is stabilized, Western Sky Community Care requires notification for hospital admission or Prior Authorization for follow-up care as noted elsewhere in this manual.

Non-Emergency Care Services

Western Sky Community Care defines non-emergent condition as any medical condition that does not fall within the description of Emergency Care Services section directly above.

Emergency Care Co-payments

An $8 per visit co-payment will be applied for use of a hospital Emergency Department (ED) to treat non-emergent conditions.

- Before providing non-emergency services and imposing co-payments, the hospital providing care must:
    - Conduct an appropriate medical screening to determine that the member does not need emergency services
    - Inform the member of the amount of his or her co-payment obligation for non-emergency services provided in the hospital ED
    - Provide the member with the name and location of an available and accessible alternative non-emergency services provider
    - Determine that the alternative provider can provide services to the member in a timely manner with the imposition of a lesser or no co-payment
    - Provide a referral to coordinate scheduling for treatment by the alternative provider

If the member has been advised of the available alternative provider and of the amount of the co-payment, and chooses to continue to receive treatment for a non-emergency condition at the hospital ED, the hospital will assess the co-payment.

Emergency services rendered for emergent conditions are exempt from any copayment.

Covered Services

Western Sky Community Care members will have the opportunity to select a Primary Care Physcian following their enrollment. Members who do not select a PCP will be assigned one. In addition to the care provided by their PCP, members may be referred to specialists by their PCP for additional care. However, members are not required to obtain a referral in order to access specialty care. They may seek care from any in-network specialist by finding an appropriate provider in the WSCC provider directory.

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines.

Non-Community Benefit Services Included Under Centennial Care

- Accredited Residential Treatment Center Services
- Applied Behavior Analysis (ABA)
- Adult Psychological Rehabilitation Services

- Ambulatory Surgical Center Services
- Anesthesia Services
- Assertive Community Treatment Services
- Bariatric Surgery
- Behavior Management Skills Development Services
- Behavioral Health Professional Services: outpatient Behavioral Health and Substance Abuse Service
- Case Management
- Community Interveners for the Deaf and Blind
- Comprehensive Community Support Services
- Day Treatment Services
- Dental Services
- Durable Medical Equipment and Supplies
- Emergency Serivces (including emergency room visits and psychiatric ER)
- Experimental or Investigational Procedures, Technology or Non-Drug Terapies
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- EPSDT Personal Care Services
- EPSDTPrivate Duty Nursing
- EPSDT Rehabilitation Services
- Family Planning
- Family Support (Behavioral Health)
- Federally Qualified Health Center Services
- Hearing Aids and Related Evaluations
- Home Health Services
- Hospice Services
- Hospital Inpatient (including Detoxification services)
- Hospital Outpatient
- Inpatient Hospitalization in Freestanding Psychiatric Hospitals
- Intensive Outpatient Program Services
- IV Outpatient Services
- Laboratory Serivces
- Medication Assistend Treatment for Opiod Dependence
- Midwife Services
- Multi-Systemic Therapy Services
- Non-Accredited Residental Treatment Centers and Group Homes
- Nursing Facility Services
- Nutritional Services
- Occupational Services
- Outpatient Hospital Based Psychiatric Services and Partial Hospitalization
- Outpatient and Partial Hospitalization in Freestanding Psychiatric Hospital
- Outpatient Health Care Professional Services
- Pharmacy Services

- Physical Health Services
- Physical Therapy
- Physician Visits
- Podiatry Services
- Pregnancy Termination Procedures
- Preventive Services
- Prosthetics and Orthotics
- Psychosocial Rehabiltation Services
- Radiology Facilities
- Recovery Services (Behavioral Health)
- Rehabilitation Option Services
- Rehabiltation Services Providers
- Reproductive Health Services
- Respite (Behavioral Health)
- Rural Health Clincis Services
- School-Based Services
- Smoking Cessation Services
- Speech and Language Therapy
- Swing Bed Hospital Services
- Telemedicine Services
- Tot-to-Teen Health Checks
- Transplant Services
- Transportation Services (medical)
- Treatment Foster Care
- Treatment Foster Care II
- Vision Care Services

Agency-Based Community Benefit Services Included Under Centennial Care 2.0

- Adult Day Health
- Assisted Living
- Behavioral Support Consulation
- Community Transition Services
- Emergency Response
- Employment Supports
- Environmental Modifications ($5,000 limit every five years)
- Home Health Aide
- Personal Care Services (Consumer Directed and Consumer Delegated)
- Private Duty Nursing for Adults
- Respite RN
- Respite (annual limits may apply)
- Skilled Maintenance Therapy Services

Self-Directed Community Benefit Services Included Under Centennial Care 2.0

- Behavioral support consulation
- Customized community support
- Emergency response
- Employment supports
- Environmental modifications ($5,00 limit every 5 years)
- Home health aide
- Self-directed personal care (formerly Homemaker)
- Nutritional counseling
- Private duty nursing for adults
- Related goods (annual limits may apply)
- Respite (annual limits may apply)
- Skilled Maintenance therapy services
- Specialized Therapies
- Transportation (Non-Medical)

Alternative Benefit Plan (ABP) Services Included Under Centennial Care 2.0

- Allergy testing and injection
- Annual physical exam and consultation
- Applied Behavioral Analysis for Autism spectrum disorder (through age 22)
- Bariatric surgery
- Behavioral Health professional and substance abuse services, evaluations, testing, assessments, therapies and medication management
- Cancer clinical trials
- Cardiovascular rehabilitation
- Chemotherapy
- Dental services
- Diabetes treatment, including diabetic shoes, medical supplies, equipment and education Dialysis
- Dialysis
- Diagnostic imaging
- Disease management
- Drug/alcohol dependency treatment services, including outpatient detoxification, therapy, partial hospitalization and intensive outpatient program (IOP) services
- Durable medical equipment, medical supplies, orthotic appliances and prosthetic devices, including repair or replacement
- Electroconvulsive therapy
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including routine oral and vision care, for individuals age 19-20
- Emergency services, including emergency room visits, emergency transportation, psychiatric emergencies and emergency dental care
- Family planning and reproductive health services and devices, sterilization, pregnancy termination and contraceptives

- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services
- Genetic evaluation and testing
- Habilitative and rehabilitative services, including physical, speech and occupational therapy
- Hearing screening as part of a routine health exam
- Holter Monitors and cardiac event monitors
- Home health care, skilled nursing and intravenous services
- Immunizations
- Inhalation therapy
- Inpatient physical and Behavioral Health hospital/medical services and surgical care
- Inpatient rehabilitative services/facilities
- IV infusions
- Lab tests, x-ray services and pathology
- Maternity care, including delivery and inpatient maternity services and pre- and post-natal care
- Medication assisted therapy for opioid addiction
- Non-emergency transportation when necessary to secure covered medical services and/or
- Nutritional evaluations and counseling – dietary evaluation and counseling as medical management of a documented disease, including obesity Organ and tissue transplants
- Osteoporosis diagnosis, treatment and management
- Outpatient surgery
- Over-the-counter medicines – prenatal drug items and low-dose aspirin as preventive for cardiac conditions
- Periodic age-appropriate testing and examinations – glaucoma, colorectal, mammography, pap tests, stool, blood, cholesterol and other preventive/diagnostic care and screenings
- Physician visits
- Podiatry and routine foot care
- Prescription medicines
- Primary Care to treat illness/injury
- Pulmonary therapy
- Radiation therapy
- Reconstructive surgery for the correction of disorders that result from accidental injury, congenital defects or disease
- Skilled nursing
- Sleep studies
- Smoking cessation treatment
- Specialist visits
- Specialized Behavioral Health services for adults: Intensive Outpatient Programs (IOP), Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR)
- Telemedicine services
- Urgent care services/facilities
- Vision care for eye injury or disease

Alternative Benefit Plan (ABP) Exemption

The following individuals are ABP Exempt and may voluntarily opt-out of the ABP:

- Individuals who qualify for medical assistance on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individuals are eligible for Supplemental Security Income benefits
- Individuals who are terminally ill and are receiving benefits for hospice care
- Pregnant women
- Individuals who are Medically Frail

Adult Members are determined to be ABP Exempt Members by either:

- Self-identifying to the Western Sky Community Care that they are exempt from mandatory enrollment into the ABP because they are an individual listed above. Adult Members may self-declare ABP Exempt status to Western Sky Community Care at any time. Upon the Member's self-identification, Western Sky Community Care, based on criteria established by HSD, will evaluate and confirm whether the Member qualifies as ABP Exempt.
- Western Sky Community Care will confirm ABP Exempt status within 10 Business Days of the Member's self-identification. The Member will remain enrolled in the ABP until Western Sky Community Care has confirmed ABP Exempt status and the Member has chosen to receive the ABP Exempt benefit package; or
- If an Adult Member does not self-identify as being ABP Exempt but Western Sky Community Care determines that the Member meets the ABP Exempt criteria listed above through the Care Coordination processes, Western Sky Community Care will notify the Member that he/she may be ABP Exempt, explain the benefit differences for ABP Exempt individuals and facilitate his/her movement into the ABP Exempt benefit package at the Member's choice.
- If the Member disagrees with Western Sky Community Care's ABP Exempt status determination, the Member may use Western Sky Community Care's grievance and appeals process as described in the Member Grievances section of this manual.

Sterilization

Sterilization procedures, such as tubal ligation and vasectomy, are covered when coordinated through a PCP and delivered by a network Provider. As a Provider, you must counsel the Member regarding alternative methods of birth control that are available. The sterilization procedure is permanent and the surgery cannot be 100% guaranteed to make him/her sterile. Inform the Member that the signed consent can be withdrawn at any time and that he/she will not lose any health services or benefits.

The Member must be at least 21 years of age, mentally competent, and not in an institution at the time he/she voluntarily signs the consent form. The Member must give informed consent and sign the Sterilization Consent Form (MA-31) (Spanish Version) at least 30 days, but no more than 180 days, before the procedure in order to receive coverage.

Abortion

An abortion is only covered in cases where the mother's life is in danger or pregnancy is the result of rape or incest.

The physician requesting authorization of coverage for an abortion must complete the Physician Certification for an Abortion Form (MA-3) (Spanish Version) prior to performing the procedure. The signed consent form must be submitted with the claim to obtain payment.

Hysterectomy

Hysterectomy surgery is covered when it is considered medically necessary and performed by a network Provider. The Provider and Member must complete the Patient Acknowledgement for Hysterectomy Form (MA-30) prior to performing the procedure. The consent form must accompany the claim to obtain payment.

School-Based Services

School-based health services provide basic health services and offer specific school programs to promote a healthy lifestyle. Western Sky Community Care Special Needs Unit will work with parents/guardians, school districts, community centers, and the PCP to provide these programs.

Non-Emergent Medical Transportation

For medically necessary non-emergent transportation requested by the Member or someone on behalf of the Member, Western Sky Community Care will require the transportation Provider to schedule transportation so that the Member arrives on time, but no sooner than one hour before the appointment. The Member will not have to wait more than one hour after the conclusion of the treatment for transportation home. Western Sky Community Care requests its participating Providers, including the transportation vendor, inform our Member Services department when a Member misses a transportation appointment. When notified of missed appointments, Western Sky Community Care can monitor and educate the Member on the importance of keeping medical appointments.

Women's Health Care

If the Member's PCP is not a women's health Specialist, Western Sky Community Care will provide direct access to a network Specialist for core benefits and services necessary to provide women routine and preventive health care. Members are allowed to utilize their own PCP or any family planning service Provider for family planning services without the need for a referral or a prior authorization.

In addition, Members will have the freedom to receive family planning services and related supplies from an out-of-network provider without any restrictions. Family planning services include examinations, assessments, traditional contraceptive services, preconception and inter-conception care services. In situations where a new Member is pregnant and already receiving care from an out-of-network OB/GYN Specialist at the time of enrollment, the Member may continue to receive services from that Specialist throughout the pregnancy and postpartum care related to the delivery.

Western Sky Community Care will make every effort to contract with all local family planning clinic and Providers and will ensure reimbursement whether the Provider is participating or out-of-network.

LTSS Service Definitions

Adult Day Health Services

Adult Day Health Services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of ABCB service members as determined by the Plan of Care incorporated into the Care Plan. Adult Day Health settings must be integrated and support full access of individuals receiving Medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The services are generally provided for two (2) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, by a licensed adult daycare, community based facility that offers health and social services to assist participants to achieve optimal functioning. Private Duty Nursing services and Skilled Maintenance Therapies (physical, occupational and speech) may be provided in conjunction with Adult Day Health services, but the Adult Day Health provider or by another provider. Private duty nursing and therapy services must be provided by licensed nurses and therapists. The Private Duty Nursing and Skilled Maintenance Therapies must be provided in a private setting at the facility. Meals provided as part of this service shall not constitute a “full nutritional regime” (3 meals per day). Transportation to and from the Adult Day Health Center must be coordinated by the Adult Day Health program.

Assisted Living

Assisted living is a residential service that provides a homelike environment which may be in a group setting, with individualized services designed to respond to the individual needs as identified by the Care Coordinator and the recipient of service, and incorporated in the Care Plan. Assisted living services include activities of daily living (i.e. ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting, and transferring) and instrumental activities of daily living (i.e. ability to care for household and social tasks to meet individual needs within the community). Assisted living is based on the following fundamental principles of practice:

- Offering quality care that is personalized for the member’s needs.
- Fostering independence for each member.
- Treating each member with dignity and respect.
- Promoting the individuality of each member.
- Allowing each member choice in care and life style.
- Protecting each member’s right to privacy.
- Nurturing the spirit of each member.
- Involving family and friends in care planning and implementation.
- Providing a safe residential environment.
- Providing safe community outings or activities.

Behavior Support Consultation

A Behavior Support Consultant (BSC) is a licensed professional as specified by applicable State laws and standards. Behavior support consultation services assist the member and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the member include: assessments, evaluations, treatments, interventions, follow-up services and assistance with challenging

behaviors and coping skill development. Services for the parents, family members and DSPs include training in dealing with challenging behaviors and assistance with coping skill development at home and in the community.

Community Transition Services

Community Transition Services are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a skilled nursing facility to a living arrangement in the community where the person is directly responsible for his or her own on-going living expenses.

This service is not intended to cover the household costs of the member's natural supports.

Allowable expenses are those necessary to enable a member to establish a basic household. Community Transition Services are furnished only when the member is unable to meet the expenses to establish his/her household or when the services cannot be obtained from other sources. Community Transition Services may not be used to furnish or establish living arrangements owned or leased by a service provider, except an assisted living facility. Services must be reasonable and necessary as determined by the MCO and authorized in the Care Plan.

Emergency Response Services

Emergency Response Services are provided through an electronic monitoring system to secure help in the event of an emergency. This service is to be used by ABCB service recipients whose safety is at risk. The member may use a portable "help" button to allow for mobility in his/her home environment. The monitoring system has a twenty-four hour, seven day a week monitoring capability. The system is connected to the member's phone and programmed to send a signal to a response center once the "help" button is activated. This response system helps ensure that the appropriate person(s) or service agency responds to alarm calls. Emergency Response Services are provided pursuant to the Care Plan.

Environmental Modifications

Environmental Modification services include the purchase and /or installation of equipment and/ or making physical adaptations to an eligible member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member's level of independence. Environmental Modifications are physical adaptations and environmental control systems excluding durable medical equipment. Environmental Modifications need to be identified in the member's Care Plan. Adaptations include the installation of ramps and hand rails; widening of doorways/hallways; installation of specialized electric and plumbing systems to accommodate medical equipment and supplies; lifts/elevators; modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, lowering counters, floor urinals and bidet adaptations and plumbing); turnaround space adaptations; specialized accessibility/safety adaptations/additions; trapeze and mobility tracks for home ceilings; automatic door openers/doorbells; voice-activated, light-activated, motion-activated, and electronic devices; fire safety adaptations; air filtering devices; heating/cooling adaptations; glass substitute for windows and doors; modified switches, outlets or environmental controls for home devices; and alarm and alert systems and/or signaling devices.

Home and Community-Based Settings (HCBS)

Home and Community-Base Settings deliver care to members in an integrated, home-based environment in order to better facilitate the integration of their daily life in and with the community around them. All HCBS care must meet the following criteria:

A. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving MedicaidHCBS.
B. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
C. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
D. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
E. Facilitates individual choice regarding services and supports, and who provides them.
F. In a provider-owned or controlled residential setting, in addition to the qualities at § 441.301(c)(4)(i) through (v), the following additional conditions must be met:
    a. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    b. Each individual has privacy in their sleeping or living unit:
        i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
        ii. Individuals sharing units have a choice of roommates in that setting.
        iii. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    c. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
    d. Individuals are able to have visitors of their choosing at any time.
    e. The setting is physically accessible to the individual.
    f. Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

i. Identify a specific and individualized assessed need.
ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
iii. Document less intrusive methods of meeting the need that have been tried but did not work.
iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
vii. Include the informed consent of the individual.
viii. Include an assurance that interventions and supports will cause no harm to the individual.

Home Health Aide

Home Health Aide Services provide total care or assist an eligible member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake.

Personal Care Services

Personal Care Services (PCS) have been established by the New Mexico Human Services Department (HSD) Medical Assistance Division (MAD or Medicaid) to assist individuals 21 years of age or older who are eligible for full Medicaid coverage and meet the nursing facility (NF) level of care (LOC) criteria and need assistance with certain ADLs and instrumental activities of daily living (IADLs). To be eligible for Personal Care Services (PCS), a member must meet all of the following criteria:

A. Be a recipient of a full benefit Medicaid category of assistance and, not be receiving other Medicaid HCBS waiver benefits, Medicaid Nursing Facility, Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID) Medicaid, PACE, or Adult Protective Services attendant care program, at the time PCS are furnished; an individual residing in a NF or ICF/IID Medicaid is eligible to apply for PCS to facilitate NF discharge; recipients of community transition goods or services may also receive PCS; all individuals must meet the Medicaid eligibility requirements to receive PCS; the MCO, Medicaid or its alternative designee must conduct a Comprehensive Needs Assessment (CNA) or evaluation to determine if the transfer to PCS is appropriate and if the PCS would be able to meet the needs of that individual;
B. Be age 21 or older;
C. Be determined to have met NF LOC by the MCO; and
D. Comply with all Medicaid and PCS regulations and procedures.

Private Duty Nursing for Adults

Private Duty Nursing Services provide members who are 21 years of age and older with intermittent or extended direct nursing care in the member's home. All services provided under Private Duty nursing require the skills of a Licensed Registered Nurse (RN) or a Licensed Practical Nurse (LPN) under a

written physician's order in accordance with the New Mexico Nurse Practice Act, Code of federal Regulation for Skilled Nursing. Nursing services are planned in collaboration with the physician, the member, and the MCO Care Coordinator. All services provided under Private Duty Nursing are pursuant to a physician's order and in conjunction with the MCO. The private duty nurse will develop and implement a Plan of Care/Treatment (CMS form 485) that is separate from the Care Plan that is developed by the MCO. Community Benefit Service members do not have to be homebound in order to receive this service. Community Benefit Service Private Duty Nursing and Medicare/Medicaid Skilled nursing may not be provided at the same time. The Private Duty Nursing service offered through the Community Benefit Service program will vary in scope and duration from Medicare and Medicaid skilled nursing. Private Duty Nursing services will be offered to members who are 21 years of age and older receiving the Community Benefit Service as the provider of last resort in accordance with the State Medicaid Plan, State Medicaid Manual, Part 4, Section 4310 and Section 4442.1. A copy of the written referral will be maintained in the member's file by the private duty nursing provider and shared with the MCO. Children (individuals under the age of 21) receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Nursing Respite Services

Nursing Respite services provide the member's primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or caregiver's illness as determined in the Care Plan. A primary caregiver is the individual who has been identified in the Care Plan and who assists the member on a frequent basis, i.e. daily or at a minimum weekly. It is not necessary for the primary caregiver to reside with the member in order to receive respite services. Nursing Respite services may be provided in the member's home, in the respite provider's home and in the community. Nursing Respite services may be provided by a Registered Nurse (RN), or a Licensed Practical Nurse (LPN). Nursing Respite services must not be provided by a member of the member's household or by any relative approved as the employed caregiver. Specific services may include the following;

A. Assistance with routine activities of daily living such as bathing, eating, meal preparation, dressing, and hygiene;
B. Assistance with routine instrumental activities of daily living such as general housekeeping;
C. Assistance with personal care services or private duty nursing services, based on the member's needs;
D. Assistance with the enhancement of self-help skills; and
E. Assistance with providing opportunities for leisure, play and other recreational activities.

Respite Services

Respite services provide the member's primary caregiver with a limited leave of absence to prevent burnout, to reduce stress and provide temporary relief to meet a family crisis, emergency or caregiver's illness as determined in the Comprehensive Care Plan (CCP). A primary caregiver is the individual who has been identified in the CCP and who assists the member on a frequent basis, i.e. daily or at a minimum, weekly. Respite provides a temporary relief to the primary caregiver during times when he/she would normally provide unpaid care. If a caregiver needs a break during the time when he/she provides paid care, the agency must provide a substitute caregiver. Respite services may be provided in the member's home, in the respite provider's home and in the community. Respite services must not be

provided by a member of the member's household or by any relative approved as the paid caregiver. Respite services are provided pursuant to the CCP, developed and authorized by the recipient of service and the Care Coordinator.

Skilled Maintenance Therapies

Skilled Maintenance Therapies include Occupational Therapy (OT), Physical Therapy (PT) and Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships.

Physical Therapy for Adults

Physical therapy is a skilled therapy service for members 21 years and older provided by licensed Physical Therapist. Physical Therapy services promote/maintain gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. A signed physical therapy referral for treatment must be obtained from the member's primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member's file by the physical therapist and shared with the MCO Care Coordinator. (Individuals under the age of 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Speech Therapy for Adults

Speech therapy is a skilled therapy service for individuals 21 years and older provided by a licensed speech and language pathologist. Speech Therapy services preserve abilities for independent function in communication; to facilitate oral motor and swallowing function, to facilitate use of assistive technology, and to prevent progressive disabilities. A signed speech therapy referral for treatment must be obtained from the member's primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member's file by the speech-language therapist and shared with the MCO Care Coordinator. Individuals under age 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Self-Directed Community Benefit (SDCB) Definitions

Behavior Support Consultation Services

Behavior Support Consultation services consist of functional support assessments, treatment plan development and training and support coordination for a SDCB member related to behaviors that compromise a member's quality of life. Behavior Support Consultation services are provided in an integrated/natural setting or in a clinical setting.

Customized Community Supports

Customized Community Support Services are designed to offer the SDCB member flexible supports that are related to the member's qualifying condition or disability. Customized Community Supports may include participation in congregate community day programs and centers that offer functional meaningful

activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include adult day habilitation, adult day health and other day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings. Customized Community Supports settings must be integrated and support full access of individuals receiving Centennial Care Community Benefits to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, with the same degree of access as individuals not receiving Medicaid HCBS. hese services are provided at least four (4) or more hours per day one (1) or more days per week as specified in the member's SDCB care plan. Customized Community Supports cannot duplicate any other SDCB service.

Emergency Response

Emergency Response services provide an electronic device that enables a member to secure help in an emergency at home and thereby avoid institutionalization. The member may also wear a portable "help" button to allow for mobility. The system is connected to the member's phone and programmed to signal a response center when a "help" button is activated. The response center is staffed by trained professionals.

Employment Supports

Employment Support services provide support to the member in achieving and maintaining employment in jobs of his/her choice in his/her community. The SDCB member must exhaust all available vocational rehabilitation supports prior to requesting Employment Supports on his/her SDCB care plan Employment Supports cannot duplicate any other SDCB service. Employment Supports include two (2) types of services: job coaching and job-development. The specific Employment Support service to be provided must be clearly described in the SDCB member's care plan and must address specific employment-related activities.

Employment Supports will be provided by staff at current or potential work sites. If member is self-employed, Employment Supports may be provided in a setting other than a formal work site. When Employment Support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving SDCB services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. Employment Supports settings must be integrated in, and support full access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Centennial Care Community Benefits.

Environmental Modification

Environmental Modification services include the purchase and/or installation of equipment and/or making physical adaptations to a SDCB member's residence that are necessary to ensure the health, welfare, and safety of the SDCB member or enhance the SDCB member's level of independence. All approved services shall be provided in accordance with applicable federal, state, and local building codes.

The Environmental Modification provider must ensure proper design criteria is addressed in the planning and design of the adaptation, provide or secure licensed contractor(s) or approved vendor(s) to provide construction services, provide administrative and technical oversight of construction projects, provide consultation to family members, providers and contractors concerning Environmental Modification projects to the SDCB member's residence, and inspect the final Environmental Modification project to ensure that the adaptations meet the approved plan submitted to the SDCB member's care coordinator for environmental adaptation.

Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to Environmental Modification projects. All services shall be provided in accordance with applicable federal, state, and local building codes.

Home Health Aide

Home Health Aide services provide total care or assist a SDCB member in all activities of daily living. Home Health Aide services assist the SDCB member in a manner that will promote and improve the SDCB member's quality of life and provide a safe environment for the SDCB member. Home health aide services can be provided outside the SDCB member's home. State plan Home Health Aide services are intermittent and are provided primarily on a short-term basis; whereas, in SDCB, Home Health Aide services are hourly services for members who need this service on a more long-term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides do not administer medication(s), adjust oxygen levels, perform any intravenous procedures or perform sterile procedures. Home Health Aide services are not duplicative of homemaker/direct support services.

Homemaker/Direct Support

Homemaker or Direct Support services are provided on an episodic or continuing basis to assist the SDCB member to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker or direct support services are provided in the member's home and in the community, depending on the member's needs. The SDCB member identifies the homemaker or direct support worker's training needs. If the SDCB member is unable to do the training him/herself, the SDCB member arranges for the needed training. Providers will bill for services in shared households within state guidelines. Two (2) or more SDCB members living in the same residence, who are receiving services and supports under SDCB will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and individual needs.

Services are not intended to replace supports available from a primary caregiver or natural supports. Although a member's assessment for the amount and types of services may vary. Homemaker or Direct Support services are not provided 24 hours a day. Allocation of time and services must be directly related to an individual's functional level to perform ADLs and IADLs as indicated in the CNA.

This service is not available for members under age 21 because personal care services are covered under the Medicaid state plan as expanded EPSDT benefits for SDCB members under age 21.

Nutritional Counseling

Nutritional Counseling services are designed to meet the unique food and nutritional needs of SDCB members. This does not include oral-motor skill development services, such as those provided by a speech pathologist.

Private Duty Nursing for Adults

Private Duty Nursing for Adults services includes activities, procedures, and treatment for a SDCB member's physical condition, physical illness or chronic disability. Children (individuals under the age of 21) receive this service through the state plan Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

Related Goods

Related Goods are services, goods, and equipment, including supplies, fees or memberships (such as for conferences or classes), which support the SDCB member to remain in the community, decrease the need for other Medicaid services and reduce the risk for institutionalization. Related goods must promote personal safety and health, accommodate the SDCB member in managing his/her household and/or facilitate activities of daily living. The related goods must not be available through another source including the Medicaid state plan and/or Medicare, and the SDCB member must not have the personal funds needed to purchase the goods.

Related goods must be documented in the SDCB care plan in a manner that clearly describes how the related good will advance the desired outcomes in the SDCB member's care plan. Related goods must be linked to the SDCB member's identified needs and are intended for the sole use of the SDCB member, and one caregiver, if appropriate. All related goods, must be approved by the MCO/UR. The cost and type of related good is subject to approval by the MCO/UR. SDCB members are not guaranteed the exact type and model of related good that is requested. The support broker and/or the care coordinator can work with the SDCB member to find other (including less costly) alternatives. Items that are purchased with SDCB funds cannot be returned for store credit, cash or gift cards. Experimental or prohibited treatments and related goods are excluded.

Respite

Respite is to be used to give the primary caregiver a break on an episodic basis in the event of an emergency or to prevent burnout. Respite provides a temporary relief to the primary caregiver of a SDCB member during times when the caregiver would normally provide unpaid care. Respite services can be provided in the SDCB member's home, the provider's home, in community setting of the family's choice (e.g., community center, swimming pool and park, or at a center in which other individuals are provided care). Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies.

Skilled Maintenance Therapies Services

Skilled Maintenance Therapies are provided when Medicaid state plan skilled therapy services are exhausted. Adult members in SDCB access therapy services under the Medicaid state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. A signed therapy referral for treatment must be obtained from the SDCB member's primary

care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered. Therapy services provided to adults in SDCB are to focus on health maintenance, improving functional independence, community integration, socialization, exercise or to enhance supports and normalization of family relationships.

A. Physical Therapy is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities.
B. Occupational Therapy is the diagnosis, assessment and management of functional limitations intended to assist adults to regain, maintain, develop and build skills that are important for independence, functioning and health.
C. Speech Language Therapy services preserve speech fluency, voice, verbal, written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal and sensor motor competencies. Speech Language Pathology is also used when a SDCB member requires the use of an augmentative communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group.

Specialized Therapies Services

Specialized Therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Services must be related to the SDCB member's disability or condition, and ensure the SDCB member's health and welfare in the community. The service will supplement to (not replace) the SDCB member's natural supports and other community services for which the SDCB member may be eligible. Experimental or investigational procedures, technologies or therapies and those services covered in Medicaid state plans are excluded. Only the specific specialized therapy services outlined below are covered in the SDCB.

Transportation (Non-Medical)

Transportation services are offered in order to enable SDCB members to gain access to and from other community services, activities and resources, as specified by the SDCB care plan. Transportation services are intended for access to the member's local area, within a 75 mile radius of the SDCB member's home. Transportation services under SDCB are non-medical in nature, whereas transportation services provided under the Medicaid state plan are to transport members to medically necessary physical and behavioral health services. Transportation for the purpose of picking up pharmacy prescriptions is allowed. Transportation for the purpose of vacation is not covered through the SDCB. Non-medical transportation services for minors is not a covered service as these are services that a LRI would ordinarily provide for household members of the same age who do not have a disability or chronic illness. Transportation is reimbursed in three (3) different ways to the driver: by the mile; by the trip; or at an hourly rate. It may also be paid through the purchase of a bus pass or local taxi. Payments are made to the SDCB member's individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the SDCB member. Whenever possible, natural supports should provide this service without charge.

NETWORK DEVELOPMENT AND MAINTENANCE

Western Sky Community Care maintains a network of qualified providers in sufficient numbers and locations that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members, both adults and children, without excessive travel requirements, and that is in compliance with DHS's access and availability requirements.

Western Sky Community Care offers a network of primary care providers to ensure every member has access to a Medical Home within the required travel distance standards.

In addition, Western Sky Community Care will have available, at a minimum, the following providers.

Specialists:

- Allergy and Asthma
- Anesthesiology
- Cardiology
- Dermatology
- General Dentistry
- General Surgery
- Neurology
- Neurosurgery
- Nursing Facility
- Obstetrics & Gynecology
- Oncology
- Ophthalmology
- Oral Surgery
- Orthopedic Surgery
- Otolaryngology
- Pharmacy
- Physical Therapy
- Radiology
- Rehabilitation Medicine
- Urology

Facilities

- Hospitals
- Laboratory services
- End state renal disease treatment and transplant centers
- Independent radiology centers

In the event Western Sky Community Care's network is unable to provide medically necessary services required under the contract, Western Sky Community Care shall ensure timely and adequate coverage of these services through an out of network Provider until a network Provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

For assistance in making a referral to a specialist or subspecialties for a Western Sky Community Care Member, please contact our Medical Management team at 844-738-5019 and we will identify a Provider to make the necessary referral.

Non-Discrimination

We do not limit the participation of any Provider or facility in the network, and/or otherwise discriminate against any Provider or facility based solely on any characteristic protected under state or federal discriminate laws.

Furthermore, we do not and have never had a policy of terminating any provider who:

- Advocated on behalf of a Member
- Filed a complaint against us
- Appealed a decision of ours

Tertiary Care

Western Sky Community Care offers a network of tertiary care inclusive of trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities and medical subspecialists available 24-hours per day in the geographical service area. In the event Western Sky Community Care's network is unable to provide the necessary tertiary care services required, Western Sky Community Care shall ensure timely and adequate coverage of these services through an out of network provider until a network provider is contracted and will ensure coordination with respect to authorization and payment issues in these circumstances.

PROJECT ECHO™

Project ECHO™ is a virtual provider to provider education model using live video tele-mentoring sessions to connect expert teams with providers in the community. Together, they participate in weekly sessions combining didactic and patient case presentations in a virtual grand rounds format. The University of New Mexico TeleECHO Clinics offer numerous curriculum options such as Chronic Pain and Opioid Management, Hepatitis C, and Endocrinology. Continuing Medical Education credits are typically offered by Project ECHO™ upon completion of the sessions.

We encourage provider participation in Project ECHO™. Providers can be reimbursed by Western Sky to present and discuss Western Sky member cases at any Project ECHO™. To enroll in this program, please contact Provider Relations at 844-738-5019 or Western Sky's Project ECHO's Telehealth Director, Jeanette Acosta-Fresquez, at JAcosta-Fresquez@salud.unm.edu.

INTEGRATED HEALTH SERVICES

Overview

Western Sky Community Care Medical Management department hours of operation are Monday through Friday from 8:00 a.m. to 5:00 p.m., MT (excluding holidays). After normal business hours, our 24/7 nurse advice hotline staff is available to answer questions about prior authorization.

Integrated Health Services include the areas of utilization management, care management, population management, and quality review. The department clinical services are overseen by the Western Sky Community Care medical director ("Medical Director"). The VP of Integrated Health Services has responsibility for direct supervision and operation of the department. To reach the Medical Director or VP of Integrated Health Services please contact Integrated Health Services: 844-831-7024.

Integrated Care

The Integrated Behavioral Health approach utilizes a holistic approach, focusing on the whole person, and includes integrating needed covered, carved out, and community-based services in its approach to care.

We use a multi-disciplinary Integrated Care Team to offer and coordinate integrated care. Our staff coordinates care with all necessary members of the designated care team, including the member's primary and specialty providers, other care team members, and those identified as having a significant role in the member's life, as appropriate.

Our overarching goal is to help each and every Western Sky Community Care member achieve the highest possible levels of wellness, functioning, and quality of life, while demonstrating positive clinical results. Integrated care is an integral part of the range of services that we provide to all members. Through this program, we continually strive to achieve optimal health status through member engagement and behavior change motivation. Integrated care does this through a comprehensive approach that includes:

- Strong support for the integration of both physical and behavioral health services
- Assisting members in achieving optimum health, functional capability, and quality of life;
- Empowering members through assistance with referrals and access to available benefits and resources
- Working collaboratively with members, family and significant others, providers, and community organizations to assist members using a holistic approach to care
- Maximizing benefits and resources through oversight and cost-effective utilization management
- Rapid and thorough identification and assessment of program participants, especially members with special health care needs
- A team approach that includes staff with expertise and skills that span departments and services
- Information technologies that support care coordination within plan staff and among a member's providers and caregivers
- Multifaceted approaches to engage members in self-care and improve outcomes

- Multiple, continuous quality improvement processes that assess the effectiveness of integrated care, and identify areas for enhancement to fully meet member priorities.
- Assessment of member's risk factors and needs;
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members understand treatment recommendations;
- Active coordination of care linking members to behavioral health practitioners and as needed medical services; including linkage with a physical health Care Coordinator for members with coexisting behavioral and physical health conditions; and residential, social and other support services where needed;
- Development of a complex care plan of care;
- Referrals and assistance to community resources and/or behavioral health practitioners; and
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral health services or compliance with treatment, we offer Care Coordination.

The model emphasizes direct member contact, such as telephonic out-reach and educational materials. Additionally some specific programs may provide face-to-face education, because it more effectively engages members, allows staff to provide information that can address member questions in real time and better meet member needs. Participating members also receive written materials, preventive care and screening reminders, invitations to community events, and can call anytime regarding health care and psychosocial questions or needs.

Recognizing that each member's clinical condition and psychosocial situation is unique, Integrated Health interventions and information meet each member's unique circumstance, and will vary from one member to another, including those with the same diagnosis.

Medically Necessary

Medically Necessary — a service, item, procedure or level of care that is necessary for the proper treatment or management of an illness, injury or disability is on that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability
- Will or is reasonably expected to reduce or ameliorate the physical, mental or developmental effects of an illness, condition or disability
- Will assist the recipient to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity or the recipient and those functional capacities are appropriate of recipients of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing. The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained health care providers.

Care Coordinators

Western Sky Community Care will assign a specific care coordinator to each Member assigned to Care Coordination level two (2) or level three (3). Care coordinators for Members in Care Coordination level two (2) or level three (3) will provide and/or arrange for the following Care Coordination services:

- Development and implementation of a Comprehensive Care Plan (CCP);
- Monitoring of the CCP to determine if the CCP is meeting the Member's identified needs;
- Assessment of need for assignment to a Health Home;
- Targeted Health Education, including disease management, based on the
- Member's individual diagnosis (as determined by the Comprehensive Needs Assessment);
- Annual Comprehensive Needs Assessment to determine if the CCP is appropriate and if a higher or lower level of Care Coordination is needed;
- At a minimum, semi-annual in-person and in-home visits with the Member;
- Two telephonic contacts shall occur as follows: (1) 60-90 Calendar Days and (2) 240-270 Calendar Days, from the most recent CNA;
- The most recent CNA completion date serves as the anchor date, or begin date, for assessing the timeliness of in-person, in-home visits and telephonic contacts. When a new CNA is conducted, that becomes the new anchor date; and
- Timeliness Schedule for a member at a Care Coordination Level 2:

Touchpoints	Deadlines
Annual CNA	Anchor Date
Telephonic Contact	60-90 Calendar Days
In-person, In-home visit	150-180 Calendar Days
Telephonic Contact	240-270 Calendar Days

Care Coordination Program

Western Sky Community Care's care coordination model is designed to help your Western Sky Community Care members obtain needed services, whether they are covered within the Western Sky Community Care array of covered services, from community resources, or from other non-covered venues. Our model will support our provider network whether you work in an individual practice or large multi-specialty group setting.

The program is based upon a coordinated care model that uses a multi-disciplinary care coordination team in recognition that a holistic approach yields better outcomes. The goal of our program is to help members achieve the highest possible levels of wellness, functioning, and quality of life, while decreasing the need for disruption at the PCP or specialist office with administrative work.

The program includes a systematic approach for early identification of eligible members, needs assessment, and development and implementation person centered care plan and person centered

service plan that includes member/family education and actively links the member to providers and support services as well as outcome monitoring and reporting back to the PCP.

Health Risk Assessment (HRA)

Upon Enrollment, the Western Sky Community Care will conduct a HRA using a tool approved by the Department to identify any unmet needs, healthcare needs requiring chronic condition or disease management, service gaps, or need for Service Coordination. Any Member whose needs screening reflects unmet needs, service gaps, or a need for Service Coordination will be referred for a comprehensive needs assessment. The needs screening must be completed within the first 30 days of Enrollment, and may be conducted by phone, electronically, by mail, or in person.

Comprehensive Needs Assessment

The comprehensive needs assessment will be scheduled within 14 days and conducted by the Care Coordinator within 30 days of enrollment for members whose HRA indicates a need for Level 2 or Level 3 Care Coordination. Reassessment will occur at a minimum of every 12 months thereafter unless there is a change in condition or significant health event or requested by the member/caregiver. This comprehensive needs assessment will be approved by the NM HSD and is used to help identify supports and services the member may need. All support and services needs are reviewed and agreed upon by the member and their identified caregiver/support. All documentation will be placed into our clinical documentation system which will support the development of the person centered service plan (PCSP). All PCSPs will require agreement and signature by the member or their designated representative as well as all providers that are part of the member's PCSP (unless the member requests to not share the PCSP with a provider(s)).

Care Coordinators will consult with the Member's PCP, specialists, Behavioral Health Providers, other Providers and interdisciplinary team experts, as needed when developing the Comprehensive Care Plan (CCP).

A Care Coordination (CC) team is available to help all providers manage their Western Sky Community Care members. Listed below are programs and components of special services that are available and can be accessed through the care coordination team. We look forward to hearing from you about any Western Sky Community Care members that you think can benefit from the addition of a Western Sky Community Care care coordination team member.

- Link the member to a Medical Home
- Educate members about Self-Management of their condition
- Ensure Member awareness of and compliance with medications
- Connect the member to needed supports
- Transition of Care Program
- ED Diversion Program
- Whole-Person Care Coordination
- Discharge planning/coordination

To contact a Care Coordinator call 844-583-2214.

High Risk Pregnancy Program

The Maternity Team will implement our *Start Smart for Your Baby*® Program (Start Smart), which incorporates care coordination and disease management with the aim of decreasing preterm delivery and improving the health of moms and their babies. Start Smart is a unique perinatal program that follows women for up to one year after delivery and includes neonates and qualified children up to one year of age.

The program goals are improving maternal and child health outcomes by providing pregnancy and parenting education to all pregnant members and providing care coordination to high and moderate risk members through the postpartum period. A nurse care coordinator with obstetrical experience will serve as lead Care Coordinator for members at high risk of early delivery or who experience complications from pregnancy. An experienced neonatal nurse will be the lead CM for newborns being discharged from the NICU unit and will follow them through the first year of life as needed based on their specific condition or diagnosis.

The Maternity team has physician oversight advising the team on overcoming obstacles, helping identify high risk members, and recommending interventions. These physicians will provide input to Western Sky Community Care Medical Director on obstetrical care standards and use of newer preventive treatments such as 17 alpha-hydroxyprogesterone caproate (17-P).

Western Sky Community Care offers a premature delivery prevention program by supporting the use of 17-P. When a physician determines that a member is a candidate for 17-P, which use has shown a substantial reduction in the rate of preterm delivery, he/she will write a prescription for 17-P. This prescription is sent to the Western Sky Community Care Care Coordinator who will check for eligibility. The Care Coordinator will assist the member with finding a pharmacy to fill the prescription as well as coordinate transportation to and from the physician's office. The nurse manager will contact the member and do an assessment regarding compliance. The nurse will remain in contact with the member and the prescribing physician during the entire treatment period. The Maternity Team works in collaboration with local PCP's, FQHC's, Health Homes and local Health Departments to support this program with the goal of improved maternity/neonate care in New Mexico.

Contact the Western Sky Community Care care coordination department for enrollment in the obstetrical program.

MemberConnections® - Community Health Services Program

Western Sky Community Care's outreach program is designed to provide education to our members on how to access healthcare and develop healthy lifestyles in a setting where they feel most comfortable.

The program components are integrated as a part of our care coordination program in order to link Western Sky Community Care and the community served. The program recruits staff from the communities serviced to establish a grassroots support and awareness of Western Sky Community Care within the community. The program has various components that can be provided depending on the need of the member.

Members can be referred to Community Health Services through numerous sources. Members who call the Western Sky Community Care Customer Service department may be referred for more personalized

discussion on the topic they are inquiring about. Care Coordinators may identify members who would benefit from one of the many Community Health Services components and complete a referral request. Providers may request Community Health Services referrals directly to the Community Health Services Representative or their assigned Care Coordinator. Community groups may request that a Community Health Services Representative come to their facility to present to groups they have established or at special events or gatherings. Various components of the program are described below.

Care Coordination – Coaching

Community Health Services Representatives are available to work with members to targeted health education, advocate, coach as well as foster the development of independent health skills, support them in addressing any social service and concrete barriers that the member faces when working to achieve whole health and wellness. The Community Health Services Representative collaborates closely with the provider, nurse care manager, team nurse manager, and other members of the interdisciplinary care team. The Community Health Services Representative works with the member in the community settings like their home, community centers, and more to provide culturally fit health education and assistance and are available whenever a need or request from a Care Coordinator, member, provider, or where a member is recommended for a specific coaching program is identified base don health status.

Navigation & Other Assistance

General assistance and navigation support may be provided to members and requested by Care Coordinator, member, or provider as needed. Topics covered during these in person visits include overview of covered benefits, how to schedule an appointment with the PCP, the importance of preventive health care, appropriate use of preventive, urgent and emergency care services, obtaining medically necessary transportation, reliable phone access through our Connections Plus® which is a free, pre-programmed cell phone with limited use. Members may use this cell phone to call the health plan Care Coordinator, PCP, specialty physician, 24/7 nurse advice hotline, 911, or other members of their health care team. Community Health Services Representatives may also ensure the member knows how to contact the health plan for assistance. Social needs may also be addressed during these visits as well to ensure wholistic care and removal of abrriers ot accesing the health care system. Community Health Services Representatives may contact new members or members in need of more personalized information to review the health plan material over the telephone. All the previous topics may be covered and any additional questions answered

Building Community Capacity

Community Health Services Representatives are available to present to group setting during events initiated by state entities, community groups, clinics, or any other approved setting. This form of community connections is extremely useful in rural areas where home visits may be the only mode of communication. Presentations may typically include what Medicaid coordinated care is all about, overview of services offered by Western Sky Community Care, how to use the health plan and access services, the importance of obtaining primary preventive care, and other valuable information related to obtaining services from providers and Western Sky Community Care and health education. Targeted community events include our Adopt-a School program where a representative will actively promote healthy lifestyle activities related to disease prevention and health promotion by going into the schools of the communities served. Commmunity Baby showers to promote health education and awareness for

healthy pregancnies and healthy babies. Health Fairs to enable easy access to providers and other health care services and more.

To contact the Community Health Services Team call 844-738-5019.

Members with Mental Health and Substance (Alcohol and Drug) Use Disorders

Western Sky Community Care uses an Intensive Care Coordination Program to address the unique needs of members related to Mental Health and Substance Use Disorders (SUD), including frequent co-morbid and co-occurring conditions which require an integrated approach to all aspects of care coordination and treatment. The program incorporates interventions such as structured post-discharge telephone or in-person contact; assessing satisfaction with outpatient providers; careful attention both to compliance with prescribed medications as well as potential impact of each medication on all PH and BH conditions.

The following programs will be initiated for members identified with needs related toMental Health and SUD as indicated:

- Health Homes
- Intensive Care Coordination
- Utilize Community Health Workers to engage members
- Transition of Care from different care settings/levels

The CC will complete an assessment to confirm member needs related to Mental Health and/or SUD,assessing medical, BH, social, and other needs. Within 30 calendar days of identification, or sooner as dictated by Member needs, a Care Coordinator will outreach to members identified with a special need to complete this comprehensive assessment, develop a care plan, and provide other needed assistance. Other outreach processes and initiatives will include:

- Partnering with community case managers, and peer supports to outreach to members with SMI, SUD, and other BH needs
- Identifying agencies serving the homeless and contacting those agencies how to best identify and reach our hard to reach or members of those with unstable housing and notify us when the Member is there
- Building relationships with local hospitals to notify us when our members come to the ED, then visiting the Member when they are admitted to the ED or hospital
- Education and enrollment of eligible members in to a Health Home Program as applicable

In an effort to support the Health Home iniative, staff will use assessment information to identify members who could benefit from a Health Home and educate eligible members on available services, including member's choice to opt in or out of the Health Home program.. For members who choose to enroll in a Health Home, the CC will coordinate with the member's chosen Health Home provider to ensure continuity of care.. Once the member is enrolled in the Health Home Program, our CC will then work with the Health Home staff and/or other members of the community-based team. to promote recovery through a care plan, developed in collaboration with the Member, that includes treatment referrals; self-management tools to help the Member understand triggers; and use of local support groups and resources. Care plans will also include coordination with the Health Home provider, other involved

providers (including OB/GYNs, BH providers, PCPs and specialists), as well as family and community supports as desired by the Member or parent/guardian.

New provider orientation and our Provider Portal will provide information on Behavioral Health (Mental Health and SUD), and co-occurring conditions, as well as our requirements and processes for screening, referring and coordinating care for individuals with these disorders. We will provide PCPs with screening tools for mental health issues and SUD, and provide training on their use.

Referrals for Care Coordination of members with needs related to Mental Health and/or SUD can be made via the Web Portal or by calling Western Sky Community Care at 844-738-5019 and completing a referral telephonically.

LONG TERM SERVICES AND SUPPORTS (LTSS)

The Provider is responsible for supervising, coordinating, and providing all authorized care to each assigned Member. In addition, the Provider is responsible for ensuring the receipt of an authorization for all services from the Member's case manager, maintaining continuity of each Member's care and maintaining the Member's medical record, which includes documentation of all services provided by the Provider as well as the Member or responsible party's signature for receipt of covered services.

Role of the Care Coordinator

The Care Coordinator (CM) assists Members obtain LTSS services. The CM leads the Person-Centered Service Plan (PCSP) process and overses the implementation of the PCSPs and Care Planning. The CM will identify, coordinate and assist the Member in gaining access to needed services: both covered and non-covered, medical, social, housing, educational and other services and supports. The Care Coordinator's Primary functions are to support the Members and facilitate access to services. The CM is responsible for locating and coordinating services, Providers, Specialists, or other entities essential for care delivery. This will include seamless coordination between physical, behavioral, and support services.

Care Coordinators work with the Member to identify strengths, goals, development of the PCSP/or IPoC, evaluations, reassessments, and leveling of care. The CM will work with the Member to complete activities necessary to maintain LTSS eligibility. The Care Coordinator will keep the Member informed, while facilitating, locating, and monitoring needed services and support. Service alternatives and other options will be taken into consideration, such as Self Directed Care, and other LTSS services. To contact a Care Coordinator, please call Western Sky Community Care at 844-738-5019.

Provider's Role in Service Planning and Care Coordination

The Provider is responsible supervising, coordinating, and providing authorized services. The Provider will also work with Care Coordinator(s) to address necessary services and supports and participate in the IPoC/PCSP to ensure continuity of the Members' needs. The Provider may participate in the Health Education Advisory Committee within the community to offer input on the health and education needs of Members. The Provider will comply with the reporting requirements of the Member Complaint, Grievance, and DHS Fair Hearing Processes. The Provider will support the Member Lock-In program by working with the Care Coordinator, the MCO, and other pertinent Providers.

Service Request Process for LTSS

Long Term Services and Supports (LTSS) services require approval and authorization by Western Sky Community Care. Service request authorizations are sent to Providers by the Western Sky Community Care Service Coordination team once the Member's comprehensive needs assessment is completed and the Member's person-centered service plan is developed, reviewed, and agreed upon with the Member and their identified caregivers/supports.

Service Plans are reviewed with Members during regularly scheduled face to face visits and assessments. If a Member experiences a significant change in condition, if there is a change in level of

support, or if the Member requests, a change in service(s) or change in placement, there may be a resulting change to the Service Plan to better meet the Member's needs.

All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Western Sky Community Care Providers are contractually prohibited from holding any Western Sky Community Care Member financially liable for any service administratively denied by Western Sky Community Care. Continuity of care coverage begins on the Member's effective date of enrollment for any existing services, and remains in effect until a comprehensive needs assessment has been completed and a PCSP has been developed and implemented.

Service Request Grievance Process

In the event a request for service is denied, a Member, Member's representative, or healthcare Provider can file a grievance. A grievance is a request to have Western Sky Community Care reconsider a decision solely concerning the medical necessity and appropriateness of a requested LTSS service.

A Member can file a grievance to dispute a decision to discontinue, reduce, or change a service. The Member must continue to receive the disputed service at the previously authorized level pending resolution of the grievance.

The Member may, in such a case, be held liable for the cost of those benefits if the appeal is not decided in favor of the Member.

In addition to the two levels of grievances, there is a Fair Hearing process. Members do not have to exhaust the complaint or grievance process prior to filing a request for a Fair Hearing. External review of second level grievances may also occur.

UTILIZATION MANAGEMENT

The Western Sky Community Care Utilization Management Program (UMP) is designed to ensure Members of Western Sky Community Care Network receive access to the right care at the right place and right time. Our program is comprehensive and applies to all eligible Members across all eligibility types, age categories, and range of diagnoses. It provides for aggregate and individual analysis and feedback of Provider and plan performance in providing access to care, the quality of care provided to Members, and utilization of services. The UMP incorporates all care settings including preventive care, emergency care, primary care, specialty care, acute care, short-term care, Health Homes, maternity care and ancillary care services.

Western Sky Community Care UMP seeks to optimize a Member's health status, sense of well-being, productivity, and access to quality healthcare, while at the same time actively managing cost trends. The UMP aims to provide services that are a covered benefit, medically necessary, appropriate to the patient's condition, rendered in the appropriate setting and meet professionally recognized standards of care.

Our program goals include:

- Development of quality standards for the region with the collaboration of the Provider Standards Committee.
- Monitoring utilization patterns to guard against over- or under- utilization
- Development and distribution of clinical practice guidelines to providers to promote improved clinical outcomes and satisfaction
- Identification and provision of care and/or population management for members at risk for significant health expenses or ongoing care
- Development of an infrastructure to ensure that all Western Sky Community Care members establish relationships with their PCPs to obtain preventive care
- Implementation of programs that encourage preventive services and chronic condition self-management
- Creation of partnerships with Members/Providers to enhance cooperation and support for UMP goals

Prior Authorizations

Failure to obtain the required approval or pre-certification may result in a denied claim(s). All services are subject to benefit coverage, limitations, and exclusions as described in applicable plan coverage guidelines. Western Sky Community Care providers are contractually prohibited from holding any Western Sky Community Care Member financially liable for any service administratively denied by Western Sky Community Care for the failure of the Provider to obtain timely authorization. All out-of-network services require Prior Authorization except for family planning, emergency room, post-stabilization services and table top x-rays.

This list is not all inclusive. Please visit https://www.westernskycommunitycare.com// and use the "Pre-Auth Needed?" tool to determine if a service requires Prior Authorization and to easily submit a request for Prior Authorization or referral.

Services That Require Prior Authorization

Ancillary Services

- Air ambulance transport (non-emergent fixed wing airplane)
- Durable Medical Equipment (DME)
- Private Duty Nursing
- Adult Day Care
- Home Health Care
- Hospice
- Respite
- Nurse Respite
- Furnished Medical Supplies and DME
- Orthotics/Prosthetics
- Genetic Testing
- Quantitative Urine Drug Screen
- Specialty Pharmaceuticals
- Therapy Services
- Out-of-Network Providers
- All Out-of-Network Providers require Prior Authorization (excluding emergency room services)

Procedures/Services

- Potentially cosmetic
- Bariatric surgery
- Transplants
- High tech imaging requests: RadMD.com
- High tech imaging administered by NIA, i.e. CT, MRI, PET
- Obstetrical ultrasound
  Two (2) allowed in nine months;
  Prior authorization required for additional ultrasound(s), except if rendered by a Perinatologist
- Pain management
- Intensive Outpatient (IOP)
- Partial Hospitalization (PHP)
- Specific procedures identified in the "Pre-Auth Needed?" tool on the Provider Portal
- Services that are experimental/investigational

Inpatient Authorization

All elective/scheduled admission notifications requested at least five days prior to the scheduled date of admission including but not limited to:

- Medical admissions
- Surgical admissions
- All services performed in out-of-network facilities
- Rehabilitation facilities
- Skilled Nursing facilities
- Inpatient Psychiatric (including detox)
- Observation stays exceeding 23 hours require Inpatient Authorization/Concurrent Review

- Outpatient Programs

Procedures for Requesting a Prior-Authorization

The preferred method for submitting authorizations is through the Secure Provider Web Portal at https://www.westernskycommunitycare.com//The Provider must be a registered user on the Secure Provider Web Portal. If the Provider is not already a registered user on the Secure Provider Web Portal and needs assistance or training on submitting Prior Authorizations, the Provider should contact his or her dedicated Provider Relations Representative. Other methods of submitting the Prior Authorization requests are as follows:

- Call the Medical Management Department at 844-831-7024. Please note: The Medical Management normal business hours are Monday – Friday 8am to 5pm. Voicemails left after hours will be responded to on the next business day.
- Fax prior authorization requests utilizing the Prior Authorization fax forms posted on https://www.westernskycommunitycare.com//. Please note: faxes will not be monitored after hours and will be responded to on the next business day.

Timeframes for Prior Authorization Requests and Notifications

Authorization must be obtained prior to the delivery of certain elective and scheduled services. The following timeframes are required for prior authorization and notification.

Any prior authorization request that is faxed or sent via the website after normal business hours (8:00 am – 5:00 pm, Monday – Friday, excluding holidays) will be processed the next business day.

Failure to obtain authorization may result in administrative claim denials.

Service Type	Timeframe
Scheduled admissions	Prior Authorization required five business days prior to the scheduled admission date
Elective outpatient services	Prior Authorization required five business days prior to the elective outpatient admission date
Emergent inpatient admissions	Notification within 24 hours to include clinical rational for admission.
Observation – 23 hours or less	Notification within one business day for non-participating providers
Emergency room and post stabilization, urgent care and crisis intervention	Notification within two business day
Maternity admissions	Notification within 24 hours.
Newborn admissions	Notification within 24 hours.
Neonatal Intensive Care Unit (NICU) admissions	Prior Authorization within 24 hours.

Authorization Determination Timelines

Western Sky Community Care decisions are made as expeditiously as the Member's health condition requires.

Type	Timeframe
Preservice/Urgent	72 hours
Preservice/Non-Urgent	Within 14 calendar days
Concurrent review	24 hours

Clinical Information

Western Sky Community Care clinical staff request clinical information minimally necessary for clinical decision making. All clinical information is collected according to federal and state regulations regarding the confidentiality of medical information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Western Sky Community Care is entitled to request and receive protected health information (PHI) for purposes of treatment, payment and healthcare operations, with the authorization of the Member.

Information necessary for authorization of covered services may include but is not limited to:

- Member's name, Member ID number
- Provider's name and telephone number
- Facility name, if the request is for an inpatient admission or outpatient facility services
- Provider location if the request is for an ambulatory or office procedure
- Reason for the authorization request (e.g. primary and secondary diagnosis, planned surgical procedures, surgery date)
- Relevant clinical information (e.g. past/proposed treatment plan, surgical procedure, and diagnostic procedures to support the appropriateness and level of service proposed)
- Admission date or proposed surgery date, if the request is for a surgical procedure
- Discharge plans
- For obstetrical admissions, the date and method of delivery, estimated date of confinement, and information related to the newborn or neonate including the date of birth and gender of infant must be provided to Western Sky Community Care within 2 business days or before discharge

If additional clinical information is required, a Western Sky Community Care representative will notify the caller of the specific information needed to complete the authorization process.

Clinical Decisions

Western Sky Community Care affirms that utilization management decision making is based on appropriateness of care and service and the existence of coverage. Western Sky Community Care does not reward practitioners or other individuals for issuing denials of service or care.

Delegated Providers must ensure that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

The treating physician, in conjunction with the Member, is responsible for making all clinical decisions regarding the care and treatment of the Member. The PCP, in consultation with the Western Sky Community Care Medical Director, is responsible for making utilization management (UM) decisions in accordance with the member's plan of covered benefits and established PC criteria. Failure to obtain authorization for services that require plan approval may result in payment denials.

Review Criteria

Western Sky Community Care has adopted utilization review criteria developed by McKesson InterQual®, the American Society of Addiction Medicine (ASAM), and the State of New Mexico Human Services Department (i.e. the Behavioral Health Collaborative), as indicated, to determine medical necessity for healthcare services. InterQual appropriateness criteria are developed by specialists representing a national panel from community-based and academic practice. InterQual criteria cover medical and surgical admissions, outpatient procedures, referrals to specialists, and ancillary services. Criteria are established and periodically evaluated and updated with appropriate involvement from physicians. All criteria are utilized as screening guides and are not intended to be a substitute for practitioner judgment. The Medical Director, or other healthcare professional that has appropriate clinical

expertise in treating the Member's condition or disease, reviews all potential adverse determination and will make a decision in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm in the screening criteria.

Providers may obtain the criteria used to make a specific adverse determination by contacting Medical Management at 844-831-7024. Practitioners also have the opportunity to discuss any adverse decisions with a physician or other appropriate reviewer at the time of notification to the requesting practitioner/facility of an adverse determination. The Medical Director may be contacted through Provider Services by calling Western Sky Community Care main toll-free phone number at 844-738-5019 and asking for a Peer Review with the Medical Director. A Care Coordinator may also coordinate communication between the Medical Director and requesting practitioner.

Members or healthcare professionals, with the Member's consent, may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing to:

Western Sky Community Care
Complaint and Grievance Coordinator

5300 Homestead Rd NE,
Albuquerque, NM 87110

Second Opinion

Members or a healthcare professional, with the Member's consent, may request and receive a second opinion from a qualified professional within the Western Sky Community Care network. If there is not an appropriate pPovider to render the second opinion within the network, the member may obtain the second opinion from an out-of-network provider at no cost to the Member. Out-of-network and in-network Providers require prior authorization by Western Sky Community Care when performing second opinions.

Assistant Surgeon

Reimbursement for an assistant surgeon's service is based on the procedure itself and the assistant surgeon's presence at the time of the procedure. Hospital medical staff by-laws that require an assistant surgeon be present for a designated procedure are not in and of themselves grounds for reimbursement as they may not constitute medical necessity, nor is reimbursement guaranteed when the patient or family requests that an assistant surgeon be present for the surgery, unless medical necessity is indicated.

New Technology

Western Sky Community Care evaluates the inclusion of new technology and the new application of existing technology for coverage determination. This may include medical procedures, drugs and/or devices. The Medical Director and/or Medical Management staff may identify relevant topics for review pertinent to the Western Sky Community Care population. The Clinical Policy Committee (CPC) reviews all requests for coverage and makes a determination regarding any benefit changes that are indicated.

If you need a new technology benefit determination or have an individual case review for new technology, please contact the Medical Management department at 844-831-7024.

Notification of Pregnancy

Members that become pregnant while covered by Western Sky Community Care may remain a Western Sky Community Care Member during their pregnancy. The managing physician should notify the Western Sky Community Care prenatal team by completing the Notification of Pregnancy (NOP) form (available at https://www.westernskycommunitycare.com//) within five days of the first prenatal visit. Providers are expected to identify the estimated date of confinement and delivery facility. See the Case Management section for information related to our Start Smart for Your Baby® program and our 17-P program for women with a history of early delivery.

Concurrent Review and Discharge Planning

Concurrent Review Nurses conduct concurrent review for inpatient admissions through onsite or telephonic methods through contact with the hospital's Utilization and Discharge Planning departments and when necessary, with the Member's attending physician. The Concurrent Review Nurse will review the Member's current status, treatment plan and any results of diagnostic testing or procedures to determine ongoing medical necessity and appropriate level of care. Concurrent review decisions will be made within one (1) business day of receipt of clinical information. For a length of stay extension request, clinical information must be submitted by 3:00 p.m. EST on the day review is due. Written or electronic notification includes the number of days of service approved, and the next review date.

Routine, uncomplicated vaginal or C-section delivery does not require concurrent review, however; the hospital must notify Western Sky Community Care within two (2) business days of delivery with complete information regarding the delivery status and condition of the newborn.

Retrospective Review

Retrospective review is an initial review of services provided to a Member, but for which authorization and/or timely notification to Western Sky Community Care was not obtained due to extenuating circumstances (i.e. Member was unconscious at presentation, Member did not have their Medicaid ID card, or otherwise indicated Medicaid coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service). Requests for retrospective review must be submitted promptly. A decision will be made within 30 calendar days following receipt of request, not to exceed 90 calendar days from date of service. Presumptive eligibility rules apply.

Speech Therapy and Rehabilitation Services

Western Sky Community Care offers our Members access to all covered, medically necessary outpatient physical, occupational and speech therapy services.

Prior authorization is required for outpatient occupational, physical or speech therapy services and should be submitted to Western Sky Community Care as described in Procedures for Requesting a Prior Authorization section of this Manual.

Advanced Diagnostic Imaging

As part of a continued commitment to further improve the quality of advanced imaging care delivered to our members, Western Sky Community Care is using National Imaging Associates (NIA) to provide prior authorization services and utilization. NIA focuses on radiation awareness designed to assist Providers in managing imaging services in the safest and most effective way possible.

Prior authorization is required for the following outpatient radiology procedures:

- CT /CTA
- MRI/MRA

Key Provisions

- Emergency room, observation and inpatient imaging procedures do not require authorization
- It is the responsibility of the ordering physician to obtain authorization
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in claim non-payment

To reach NIA and obtain authorization, please call 800-424-1750 and follow the prompt for radiology authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information or call our Provider Services department.

Cardiac Solutions

Western Sky Community Care, in collaboration with NIA Magellan, will launch a cardiac imaging program to promote health care quality for patients with possible cardiac disease.

Under this program, prior authorization will be required for certain cardiac studies to determine if the cardiac test or procedure is the most appropriate next step in a patient's diagnosis or treatment—and to recommend an alternate approach when indicated. By supporting the most efficient diagnosis and management of cardiac disease, NIA Magellan addresses unnecessary procedures and promotes the least invasive, most medically appropriate approach.

NIA Magellan has developed proprietary utilization management guidelines for these cardiac modalities. These consensus-based guidelines draw on current literature, American College of Cardiology (ACC) appropriateness criteria, recommendations from the American Heart Association, and input from our Cardiac Advisory Board and other experts. Our guidelines are transparent and available throughout our programs. NIA Magellan also includes references to the Choosing Wisely campaign by the American Board of Internal Medicine (ABIM) Foundation, which provides specialty society considerations for the selection of appropriate tests.

How does this program improve patient health?

Managing cardiac studies will promote the use of optimal diagnostic methods in the assessment and treatment of cardiac diseases. Based on criteria adapted from the ACC and AMA, this program will

minimize patients' radiation exposure by using the most efficient and least invasive testing options available.

Program Components

Evidence-based clinical guidelines and proprietary algorithms to support clinically appropriate diagnostic options for each patient

Consultations with cardiologists related to elective cardiac diagnostic imaging, when needed

Quality assessment of imaging providers to ensure the highest technical and professional standards

How the Program Works

In addition to the other procedures that currently require prior authorization for Members, prior authorization will be required for the following cardiac procedures:

- Myocardial Perfusion Imaging (MPI)
- MUGA Scan
- Echocardiography
- Stress Echocardiography

The following services do not require authorization through NIA Magellan:

- Inpatient advanced radiology services
- Observation setting advanced radiology services
- Emergency Room radiology services

To reach NIA and obtain authorization, please call 800-424-1750and follow the prompt for radiology and cardiac authorizations. NIA also provides an interactive website which may be used to obtain on-line authorizations. Please visit RadMD.com for more information.

CLINICAL PRACTICE GUIDELINES

Western Sky Community Care clinical and quality programs are based on evidence based preventive and clinical practice guidelines. Whenever possible, Western Sky Community Care adopts guidelines that are published by nationally recognized organizations or government institutions as well as state-wide collaborative and/or a consensus of healthcare professionals in the applicable field.

Western Sky Community Care providers are expected to follow these guidelines and adherence to the guidelines will be evaluated at least annually as part of the Quality Management Program. Following is a sample of the clinical practice guidelines adopted by Western Sky Community Care:

- American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care
- American Diabetes Association: Standards of Medical Care in Diabetes
- Center for Disease Control and Prevention (CDC): Adult and Child Immunization Schedules
- National Heart, Lung, and Blood Institute: Guidelines for the Diagnosis and Management of Asthma and Guidelines for Management of Sickle Cell
- U.S. Preventive Services Task Force Recommendations for Adult Preventive Health
- American Psychiatric Association

For links to the most current version of the guidelines adopted by Western Sky Community Care, visit our website at https://www.westernskycommunitycare.com//. A paper copy of the practice guidelines can be requested by calling the Provider Relations department at 844-738-5019.

PHARMACY

Western Sky Community Care is committed to providing appropriate, high quality, and cost-effective outpatient medications when determined to be medically necessary to all Western Sky Community Care Members. We work with Providers and Pharmacists to ensure medications used to treat a variety of conditions and diseases are covered pharmacy benefits.

Western Sky Community Care covers prescription drugs and certain over-the-counter (OTC) drugs when ordered by a Western Sky Community Care prescriber. The pharmacy program covers all medications that are Medicaid covered outpatient drugs. Certain medications may require prior authorization (PA) and/or have limitations on age, dosage and/or maximum quantities. Through, an exception process authorizations are granted for these medically necessary medications.

This section provides an overview of Western Sky Community Care pharmacy program. For more detailed information, please visit our website at https://www.westernskycommunitycare.com//.

Working With the Pharmacy Benefit Manager (PBM)

Western Sky Community Care works with Envolve Pharmacy Solutions to administer pharmacy benefits, including the Prior Authorization process. Certain drugs require Prior Authorization to be approved for payment by Western Sky Community Care.

These include:

- All medications not listed on the Preferred Drug List (PDL)
- Some Western Sky Community Care preferred drugs (designated PA on the Preferred Drug List)

Pharmacy Prior Authorization

The Western Sky Community Care PDL includes a broad spectrum of brand name and generic drugs. PrescribersClinicians are encouraged to prescribe from the Western Sky Community Care PDL for their patients who are Members of Western Sky Community Care. Some drugs will require PA (Prior Authorization). In addition, all non-excluded drugs not listed on either the PDL or PA list will require prior authorization. Western Sky Community Care will cover the medication if it is determined that:

1. There is a medical reason the Member needs the specific medication.
2. Depending on the medication, other medications on the PDL have not worked.

Drug Prior Authorization request can be submitted to Envolve Pharmacy Solutions through phone, fax or online. To ensure timeliness of our Members' pharmacy needs, Western Sky Community Care has a strict twenty four (24) hour turnaround time requirement to process these requests.

Phone

- Prescribers may call Envolve Pharmacy Solutions to initiate a Prior Authorization by calling 844-792-2436

- The Envolve Pharmacy Solutions Prior Authorization (PA) Help Desk is staffed with PA Triage Specialists Monday through Friday, 9:00 AM to 8:00 PM (EST)
- During regular business hours, licensed Clinical Pharmacists and Pharmacy Technicians are available to answer questions and assist Providers. A nurse advice line is available to assist Providers outside regular business hours.

FAX

- Prescribers may complete the Western Sky Community Care/Envolve Pharmacy Solutions Medication Prior Authorization Request form, found on the Western Sky Community Care website at https://www.westernskycommunitycare.com.
- Fax to Envolve Pharmacy Solutions at 866-399-0929.
- Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax.
- When medical necessity criteria is not met based on the clinical information submitted, the prescriber will be notified of the reason via fax. The notification will include PDL alternatives if applicable.

Online Prior Authorization - Pharmacy

- CoverMyMeds is an online drug prior authorization (PA) program through Envolve Pharmacy Solutions that allows prescribers to begin the PA process electronically. Prescribers locate the correct form, fill it out online, and then submit it to Envolve Pharmacy Solutions via fax. CoverMyMeds simplifies the PA submission process by automating drug prior authorizations for any medication.
- CoverMyMeds can be found at https://www.covermymeds.com/epa/envolverx/

All reviews are performed using the criteria established by the Western Sky Community Care P&T Committee.New Mexico Once approved, Envolve Pharmacy Solutions notifies the prescriber/clinician by fax. If the clinical information provided does not meet the medical necessity and or prior authorization guidelines for the requested medication, Western Sky Community Care will notify the Member and the prescriber of medication alternatives in addition to provide information for the appeal process.

Pharmacy Claim Submission

For Envolve Pharmacy Solutions Pharmacy Paper Claim submissions, send correspondence to:

Attn: Envolve Pharmacy Solutions Pharmacy
Claim Submission
5 River Park Place East, Suite 210
Fresno, CA 93720

Preferred Drug List (PDL)

The Western Sky Community Care Preferred Drug List (PDL) can be found online at https://www.westernskycommunitycare.com// and describes the circumstances under which contracted pharmacy Providers will be reimbursed for medications dispensed to Members covered under the

program. All drugs covered under the Centennial Care program are available for Western Sky Community Care Members. The PDL includes all therapies available with and without PA in alignment with CMS covered outpatient medications. The PDL applies to all medications a Member may receive at network outpatient pharmacies. The PDL is continually evaluated by the Western Sky Pharmacy and Therapeutics (P&T) Committee to promote the appropriate and cost-effective use of medications. The Committee is composed of the Western Sky Community Care Medical Director, Pharmacy Director, and several New Mexico primary care physicians, behavioral health specialist, pharmacists, and healthcare Providers.

The Preferred Drug List does not:

- Require or prohibit the prescribing or dispensing of any medication
- Substitute for the independent professional judgment of the Provider or Pharmacist
- Relieve the Provider or Pharmacist of any obligation to the Member or others

The Western Sky Community Care PDL includes a broad spectrum of generic and brand name drugs. Some preferred drugs require Prior Authorization (PA). Medications requiring PA are listed with a “PA” notation throughout the PDL.

A paper copy of the current PDL can be requested by calling Provider Relations department at number provided in the Key Contacts section of this manual.

Pharmacy Co-payments

An $8 per prescription co-payment will be applied for non-preferred prescription drugs. A non-preferred prescription drug is a Medicaid-covered prescription drug item that is not on the first tier of the preferred drug list (PDL). In some circumstances a name-brand drug may be considered preferred.

The co-payment does not apply if the following conditions are met:

- The prescriber estimates that the lower-cost alternative drug item available on the PDL is either less effective for treating the member’s condition, would create more side effects, or a has higher risk of adverse reactions; and
- The prescriber has stated that the non-preferred drug is medically necessary on the prescription and the claim is billed with a “dispense as written” indicator.

If there is no medical justification for the use of a non-preferred drug, the co-payment is to be assessed by the pharmacy provider.

Certain presecription drugs are exempt from the non-preferred prescription drug copayment. The following categories of pharmaceuticals include drugs from the following categories:

- Family planning prescription drug items, supplies, and devices
- Prenatal drug items
- Immunizations
- Legend drugs that are classified as psychotropic drugs for the treatment of behavioral health conditions. Minor tranquilizers, sedatives, hypnotics, and stimulants to treat attention deficit disorders are not considered psychotropic medications.

Pharmacy and Therapeutics Committee (P&T)

The Western Sky Community Care Pharmacy and Therapeutics (P&T) Committee continually evaluates the therapeutic classes included in the PDL. The primary purpose of the Committee is to assist in developing and monitoring the Western Sky Community Care PDL in establishing programs and procedures that promote the appropriate and cost-effective use of medically necessary medications. The P&T Committee schedules meetings 4 times a year, and coordinates reviews with the National P&T Committee's meeting schedule. Revisions to Western Sky Community Care PDL that adversely impacts our Members will be communicated at least 60-days in advance of those changes.

72 Hour Emergency Supply of Medications

Federal law requires that a pharmacy dispense a 72-hour supply of medication in an emergency situation. Western Sky Community Care will allow a 72-hour supply of medication to any patient awaiting a prior authorization determination. The purpose is to avoid interruption of current therapy or delay in the initiation of therapy. All participating pharmacies are authorized to provide a 72 hour supply of medication and will be reimbursed for the ingredient cost and dispensing fee of the 72 hour supply of medication, whether or not the PA request is ultimately approved or denied. The pharmacy will contact the Envolve Pharmacy Solutions Pharmacy Help Desk at 844-792-2436 for a prescription override to submit the 72 hour medication. The Pharmacy help desk call center is available 24 hours a day, 7 days a week.

Newly Approved Products

We review new drugs for safety and effectiveness before adding them to the Western Sky Community Care PDL. During this period, access to these medications will be granted to all new drugs approved by the Food and Drug Administration (FDA) and meet the definition of a Covered Outpatient Drug, either by addition to the PDL, or through prior authorization, within 10 days from their availability in the marketplace.

Benefit Exclusions

The following drug categories are not part of the Western Sky Community Care benefit and are not covered by the 72- hour emergency supply policy:

- Fertility enhancing drugs
- Anorexia, weight loss, or weight gain drugs
- Drug Efficacy Study Implementation (DESI) and Identical, Related and Similar (IRS) drugs that are classified as ineffective
- Drugs and other agents used for cosmetic purposes or for hair growth
- Erectile dysfunction drugs prescribed to treat impotence
- Exclusions as specified by Centennial Care
- Bulk powders, because there is a lack of substantial evidence of effectiveness for all labeling indications and because a compelling justification for their medical need has not been established.
- Drugs and devices classified as experimental by the FDA
- Drugs and devices not approved by the FDA

Specialty Pharmacy Program

AcariaHealth is the provider of specialty medications for Western Sky Community Care. Most specialty medications require a prior authorization to be approved for payment; Follow the prior authorization guidelines for the most efficient processing of your authorization requests.

Providers can request that AcariaHealth delivery the specialty drug to the office or the medication can be delivered to the member.

AcariaHealth phone number – (855) 535-1815

Dispensing Limits, Quantity Limits and Age Limits

Drugs may be dispensed up to a maximum 34 day supply for each new or refill non-opioid. A member may receive a 100 day supply for specific maintenance medications. A total of 85 percent (85%) of the days supplied for a non-controlled medication and 90 percent (90%) for controlled substances must have elapsed before the prescription can be refilled without a Prior Authorization approval. A prescription can be filled after 26 days. Dispensing outside the quantity limit (QL) or age limits (AL) requires Prior Authoziation. Western Sky Community Care may limit how much of a medication a Member can get at one time. If the physician/clinician feels a Member has a medical reason for getting a larger amount, he or she can ask for Prior Authorization. If Western Sky Community Care does not grant a Prior Authoization approval, we will notify the Member and physician/clinician and provide information regarding the appeal process. Some medications on the Western Sky Community Care PDL may have age limits. These are set for certain drugs based on Food and Drug Administration (FDA) approved labeling and for safety concerns as well as current medically accepted quality standards of care as

supported by clinical literature. There is always consideration of the exception process for medically necessary treatments.

Mandatory Generic Substitution

Generic drugs have the same active ingredient, work the same as brand name drugs, and have lower copayments. If the Member or physician/clinician feels a brand name drug is medically necessary, the physician/clinician can ask for an authorization. We will cover the brand name drug according to our clinical guidelines if there is a medical reason the Member needs the particular brand name drug. If Western Sky Community Care does not grant authorization we will notify the Member and physician/clinician and provide information regarding the appeal process.

Over-The-Counter Medications (OTC)

The pharmacy program covers approved OTC medications listed in the Preferred Drug List. All OTC medications must be written on a valid prescription by a licensed physician in order to be reimbursed.

Pharmacy Lock-In Program

Western Sky Community Care maintains a Member Pharmacy Lock-In program to prevent the abuse or oversue of services.

Pharmacy claims will be audited on a monthly basis using selected criteria from the list below to identify potential misuse of the prescription benefit.

The following are concerns by which a member need only meet one criteria to be considered for pharmacy lock-in.

- Prescriptions written on a stolen, forged or altered prescription blank issued by a licensed prescriber which led to a Member conviction within the past 24 months.
- Member has diagnosis in the past 24 months of drug poisoning or drug or alcohol abuse on file or a diagnosis of suicide attempt or suicide ideations. Illicit drug abuse or dependency may be counted as well.
- Referrals from the providers reporting suspected abuse
- Member had 2 or more violations of a pain contract with the same or different prescriber in a 24 month period.

The following are concerns by which a member needs to meet two or more criteria items to be considered for pharmacy lock-in.

- Prescribed medications do not correlate with the Member's medical condition, as identified by his/her PCP, or ICD-10 code from encounter data;
- Member has filled controlled prescriptions at three or more pharmacies per 90 day period. Pharmacies are distinct and do not share a database.
- Member receives 7 or more controlled substances (overlapping or duplicative) from 2 or more doctors in any 90 day period. The doctors are not affiliated in the same practice.
- Member receives overlapping or duplicative psychiatric medications or anxiety agents from two or more providers in any 90 day period. Providers are not affiliated in the same practice.

- Member receives repeated, overlapping opiate scripts from two or more unaffiliated prescribers lasting 6 weeks or longer in any 90 day period;
- Member has been seen in Hospital Emergency Room with excessive non-emergent claims. Example; tooth ache, back pain, contusion, etc. Example more than 2 times in any 90 day period in a year.
- Member has a high Morphine Equivalency Dose of great than or equal to 90 morphine milligram equivalents month in any 90 day period. If there are any cash claims known these can be factored into the total MME.
- Members has claims in profile of high abuse potential such as combinations of opiates, muscle relaxers and benzodiazepines in any 90 day period.

Prior to placing a member on pharmacy lock-in, Western Sky will inform the member, pharmacy and prescriber of the intent to lockin and be give them the grievance procedure.

The on-line adjudication system will be updated with the lock-in information to enforce the edit. The member can obtain a 72 hour emergency supply of medication at pharmacies other than th designated lock-in pharmacy in case of emergency. The pharmacy can request the override by calling the pharmacy help desk.

All lock-in members will be reviewed periodically for program adherence and to determine if the lock-in restriction should be removed.

PROVIDER RELATIONS AND SERVICES

Provider Relations

Western Sky Community Care's Provider Relations department is committed to supporting Providers as they care for our Members. Through Provider orientation, ongoing training and support of daily business operations, we will strive to be your partners in good care. Upon credentialing approval and contracting, each Provider will be assigned a Provider Relations representative. Within 30 days of the Provider's effective date, the Provider Relations representative will contact the provider to schedule an orientation.

Reasons to Contact a Provider Relations Representative

- Report any changes to your practice (locations, NPI, TIN numbers)
- Initiate credentialing of a new practitioner
- Schedule an in-service training for new staff
- Conduct ongoing education for existing staff
- Obtain clarification of policies and procedures
- Obtain clarification of a provider contract
- Request fee schedule information
- Obtain Member roster
- Obtaining Provider Profiles
- Learn how to use electronic solutions on web authorizations, claims submissions and Member eligibility
- Open/close patient panel

Provider Services

Provider Services is available at 844-738-5019 Monday through Friday 8am to 5pm and closed on state holidays.

CREDENTIALING AND RE-CREDENTIALING

Overview

The purpose of the credentialing and re-credentialing process is to help make certain that Western Sky Community Care maintains a high quality healthcare delivery system. The credentialing and re-credentialing process helps achieve this aim by validating the professional competency and conduct of our Providers. This includes verifying licensure, board certification, and education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Base. Participating providers must meet the criteria established by Western Sky Community Care, as well as government regulations and standards of accrediting bodies.

Western Sky Community Care requires re-credentialing at a minimum of every 3 years because it is essential that we maintain current Provider professional information. This information is also critical for Western Sky Community Care's Members, who depend on the accuracy of the information in its Provider directory.

Note: In order to maintain a current Provider profile, Providers are required to notify Western Sky Community Care of any relevant changes to their credentialing information in a timely manner.

Which Providers Must be Credentialed?

The following Providers are required to be credentialed:

Medical practitioners

- Medical doctors
- Oral surgeons
- Chiropractors
- Osteopaths
- Podiatrists
- Nurse practitioners
- Other medical practitioners

Behavioral healthcare practitioners

- Psychiatrists and other physicians
- Addiction medicine specialists
- Doctoral or master's-level psychologists
- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Other behavioral healthcare specialists

Information Provided at Credentialing

All new practitioners and those adding practitioners to their current practice must submit at a **minimum** the following information when applying for participation with Western Sky Community Care:

- A completed, signed and dated Credentialing application
- Providers can authorize Western Sky Community Care access to their information on file with the CAQH (Council for Affordable Quality Health Care) www.CAQH.org
- A signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Current malpractice insurance coverate detailed on the credentialing application or a copy of current malpractice insurance policy face sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with New Mexico regulations regarding malpractice coverage or alternate coverage
- Copy of current Drug Enforcement Administration (DEA) registration Certificate
- Copy of W-9
- Copy of Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if applicable
- Curriculum vitae listing, at minimum, a five year work history (not required if work history is completed on the application)
- Signed and dated release of information form not older than 90 days
- Proof of highest level of education – copy of certificate or letter certifying formal post-graduate training
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Disclosure of Ownership & Controlling Interest Statement

If applying as an individual practitioner or group practice, please submit the following information along with your signed participation agreement:

- A completed, signed and dated New Mexico Standardized Credentialing application

If applying as an ancillary or clinic Provider, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO)
  - If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)

- Disclosure of Ownership & Controlling Interest Statement
- Other applicable State/Federal/Licensures (e.g. CLIA, DEA, Pharmacy, or Department of Health)
- Copy of W-9

If applying as a hospital, please submit the following information along with your signed participation agreement:

- Hospital/Ancillary Provider Credentialing Application Completed (one per Facility/Hospital/Ancillary Provider)
- Copy of State Operational License
- Copy of Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO)
  - If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)
- Disclosure of Ownership & Controlling Interest Statement
- Copy of W-9

Once Western Sky Community Care has received an application, it verifies the following information, at a minimum, submitted as part of the Credentialing process (please note that this information is also re-verified as part of the re-credentialing process):

- Current participation in the New Mexico Medicaid Program
- A current New Mexico license through the appropriate licensing agency
- Board certification, or residency training, or medical education
- National Practitioner Data Bank (NPDB) for malpractice claims and license agency actions
- Hospital privileges in good standing or alternate admitting arrangements
- Five year work history
- Social Security Death Master File
- Federal and state sanctions and exclusions including the following sources:
  a. Office of Inspector General (OIG)
  b. The System for Award Management (SAM)
  c. Medicare Opt-Out Listing
  d. New Mexico List of Excluded Individuals/Entities

Once the application is complete, the Western Sky Community Care Credentialing Committee (Credentialing Committee) renders a final decision on acceptance following its next regularly scheduled meeting.

Credentialing Committee

The Credentialing Committee is responsible for establishing and adopting as necessary, criteria for Provider participation. It is also responsible for termination and direction of the credentialing procedures, including Provider participation, denial and termination.

Committee meetings are held at least monthly and more often as deemed necessary.

Note: Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process prior to committee decision.

Re-Credentialing

To comply with accreditation standards, Western Sky Community Care re-credentials Providers at least every 36 months from the date of the initial credentialing decision. The purpose of this process is to identify any changes in the practitioner's licensure, sanctions, certification, competence, or health status that may affect the ability to perform services the Provider is under contract to provide. This process includes all Providers, primary care Providers, Specialists and ancillary Providers/facilities previously credentialed to practice within the Western Sky Community Care network.

In between credentialing cycles, Western Sky Community Care conducts ongoing monitoring activities on all network providers. This includes an inquiry to the appropriate state licensing agency to identify newly disciplined providers and providers with a negative change in their current licensure status. This monthly inquiry helps make certain that providers are maintaining a current, active, unrestricted license to practice in between credentialing cycles. Additionally, Western Sky Community Care reviews monthly reports including OIG, SAM, and Medicare Opt Out to identify network Providers who have been newly sanctioned or excluded from participation in federal and state programs.

Loss of Network Participation

A Provider's agreement may be terminated at any time if Western Sky Community Care's Credentialing Committee determines that the Provider no longer meets the credentialing requirements.

Upon notification from the Department that a Provider with whom Western Sky Community Care has entered into an agreement is suspended or terminated from participation in the Medicaid or Medicare Programs, Western Sky Community Care will immediately act to terminate the Provider from participation. Terminations for loss of licensure and criminal convictions will coincide with the effective date of the action.

Right to Review and Correct Information

All Providers participating within the Western Sky Community Care network have the right to review information obtained by the Health Plan that is used to evaluate Providers' credentialing and/or re-credentialing applications. This includes information obtained from any outside primary source such as the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and state licensing agencies. This does not allow a Provider to review peer review-protected information such as references, personal recommendations, or other information.

Should a Provider identify any erroneous information used in the credentialing/re-credentialing process, or should any information gathered as part of the primary source verification process differ from that submitted by the Provider, the Provider has the right to correct any erroneous information submitted by another party. To request release of such information, a provider must submit a written request to Western Sky Community Care's Credentialing Department. Upon receipt of this information, the provider

has 14 days to provide a written explanation detailing the error or the difference in information. The Western Sky Community Care Credentialing Committee will then include the information as part of the credentialing/re-credentialing process.

Right to Be Informed of Application Status

All Providers who have submitted an application to join Western Sky Community Care have the right to be informed of the status of their application upon request. To obtain status, contact your Provider Network Specialist at 844-738-5019.

Right to Appeal Adverse Credentialing Determinations

Western Sky Community Care may decline an existing Provider applicant's continued participation for reasons such as quality of care or liability claims issues. In such cases, the Provider has the right to request reconsideration in writing within 14 days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation in the Western Sky Community Care network. The Credentialing Committee will review the reconsideration request at its next regularly scheduled meeting, but in no case later than 60 days from the receipt of the additional documentation. Western Sky Community Care will send a written response to the Provider's reconsideration request within two weeks of the final decision.

Disclosure of Ownership and Control Interest Statement

Federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require Providers who are entering into or renewing a Provider agreement to disclose:

- The identity of all owners with a control interest of *5%* or greater
- Certain business transactions as described in 42 CFR 455.105
- The identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity

Western Sky Community Care furnishes Providers with the Disclosure of Ownership and Control Interest Statement as part of the initial contracting process. This form should be completed and returned along with the signed Provider agreement. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Western Sky Community Care within 30 days of the change. Please contact Western Sky Community Care Provider Relations Department at 844-738-5019 if you have questions or concerns regarding this form, or if you need to obtain another copy of the form.

RIGHTS AND RESPONSIBILITIES

Member Rights

Members have certain rights. Western Sky Community Care expects Providers to respect and honor Members' rights, including:

- To be treated with respect and dignity
- To pick or change doctors from the list of doctors in our Provider Network
- To be able to get in touch with the Provider
- To go to any Provider or clinic that provides Family Planning services
- To get care right away for an Emergency Medical Condition
- To be told about their illness or medical problem is and what the Provider thinks is the best way to treat it
- To decide about their health care and to give permission before the start of diagnosis, treatment, or surgery
- To have the personal information in medical records kept private
- To report any complaint or grievance about a Provider or medical care
- To file an appeal of an action that reduces or denies services based on medical criteria
- To receive interpretation services
- To not be coerced into making decisions about treatment
- To not be discriminated against due to race, color, national origin or health status or the need for health care services
- To have the right to request a second opinion
- To be notified at the time of enrollment and annually of disenrollment rights
- Other Member rights and protections, as specified in 42 CFR § 438.100
- To make an Advance Directive
- To file any complaint about not following Advance Directives with the New Mexico Department of Health
- To choose a Provider who gives care whenever possible and appropriate
- To receive accessible healthcare services comparable in amount, duration and scope to those provided under Medicaid FFS and sufficient in amount, duration and scope to be reasonably expected to achieve the purpose for which the services are furnished
- To receive appropriate services not denied or reduced solely because of diagnosis, type of

illness or medical condition

- Freedom to exercise the rights described herein without any adverse effect on the treatment by New Mexico Department of Health, Western Sky Community Care, its providers or contractors
- To receive all written member information from Western Sky Community Care:
    - At no cost to the Member
    - In the prevalent non-English languages of Members in the service area
    - In other ways, to help with the special needs of Members who may have trouble reading the information for any reason
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as “prevalent”
- To be notified that oral interpretation services are available and how to access them
- To get help from both New Mexico Department of Health and its Enrollment Broker in understanding the requirements and benefits of Western Sky Community Care

Member Responsibilities

Members have certain responsibilities:

- A description of procedures to follow if:
    - Member family size changes
    - Member moves out of the Region, out-of-state or have other address changes
- Member obtains or has health coverage under another policy, other third party, or there are changes to that coverage
- Allow Western Sky Community Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs
- To take actions toward improving their own health, their responsibilities and any other information deemed essential by Western Sky Community Care
- Information about the process that members and providers must follow when requesting non-emergent inpatient hospitalization Prior Authorization, including how to notify Western Sky Community Care of an inpatient admission for non-emergent care
- Information on any of cost-sharing responsibilities
- To inform Western Sky Community Care of the loss or theft of a member ID card
- To present member ID card(s) when using healthcare services
- To be familiar with Western Sky Community Care procedures and coverage rules and

restrictions to the best of the Member's abilities

- To call or contact Western Sky Community Care to obtain information and have questions clarified
- To provide Providers with accurate and complete medical information
- To follow prescribed treatment of care recommended by a provider or letting them know the reason(s) treatment cannot be followed, as soon as possible
- To ask questions of providers to determine the potential risks, benefits, and costs of treatment alternatives and make care decisions after weighing all factors
- To understand health problems and participate in developing mutually agreed upon treatment goals with their provider to the highest degree possible
- To follow the Grievance process established by Western Sky Community Care (and as outlined in the member Handbook) if there is a disagreement with a Provider

Provider Rights

Western Sky Community Care Providers have the **right** to:

- Be treated by their patients and other healthcare workers with dignity and respect
- Receive accurate and complete information and medical histories for Members' care
- Have their patients act in a way that supports the care given to other patients and that helps keep the doctor's office, hospital, or other offices running smoothly
- Expect other network providers to act as partners in Members' treatment plans
- Expect Members to follow their directions
- File an appeal against Western Sky Community Care for payment issues and/or utilization management, or a general grievance against Western Sky Community Care and/or a Member
- File a grievance with Western Sky Community Care on behalf of a Member, with the Member's consent
- Have access to information about Western Sky Community Care Quality Improvement programs, including program goals, processes, and outcomes that relate to member care and services
- Contact Western Sky Community Care Provider Services with any questions, comments, or problems
- Collaborate with other healthcare professionals who are involved in the care of Members

Provider Responsibilities

Western Sky Community Care providers have the **responsibility** to:

- Help Members or advocate for Members to make decisions within their scope of practice about their relevant and/or medically necessary care and treatment, including the right to:
  - Recommend new or experimental treatments
  - Provide information regarding the nature of treatment options
  - Provide information about the availability of alternative treatment options, therapies, consultations, and/or tests, including those that may be self-administered
  - Be informed of the risks and consequences associated with each treatment option or choosing to forego treatment as well as the benefits of such treatment options
- Treat Members with fairness, dignity, and respect
- Not discriminate against Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency
- Maintain the confidentiality of members' personal health information, including medical

records and histories, and adhere to state and federal laws and regulations regarding confidentiality

- Give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider's practice/office/facility
- Provide Members with an accounting of the use and disclosure of their personal health information in accordance with HIPAA
- Allow Members to request restriction on the use and disclosure of their personal health information
- Provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records
- Provide clear and complete information to Members, in a language they can understand, about their health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process
- Tell a Member if the proposed medical care or treatment is part of a research experiment and give the Member the right to refuse experimental treatment
- Allow a Member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal
- Respect Members' Advance Directives and include these documents in the Members' medical record
- Allow Members to appoint a parent, guardian, family member, or other representative if they can't fully participate in their treatment decisions
- Allow Members to obtain a second opinion, and answer Members' questions about how to access healthcare services appropriately
- Follow all state and federal laws and regulations related to patient care and patient rights
- Participate in Western Sky Community Care data collection initiatives, such as HEDIS and other contractual or regulatory programs
- Review clinical practice guidelines distributed by Western Sky Community Care
- Comply with Western Sky Community Care Medical Management program as outlined in this handbook
- Disclose overpayments or improper payments to Western Sky Community Care
- Not deny services to a member due to inability to pay the co-payment if the household income is at or below 100% FPL.
- Reimburse co-payments to members who have been incorrectly overcharged.
- Provide Members, upon request, with information regarding the Provider's professional

qualifications, such as specialty, education, residency, and board certification status

- Obtain and report to Western Sky Community Care information regarding other insurance coverage
- Notify Western Sky Community Care in writing if the provider is leaving or closing a practice
- Update their enrollment information/status with the New Mexico Medicaid program if there is any change in their location, licensure or certification, or status via the New Mexico Medicaid's Provider Web Portal
    - https://nmmedicaid.portal.conduent.com/static/index.htm
- Contact Western Sky Community Care to verify Member eligibility or coverage for services, if appropriate
- Invite Member participation, to the extent possible, in understanding any medical or behavioral health problems they may have and to develop mutually agreed upon treatment goals, to the extent possible
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages, including the ability to communicate with sign language
- Office hours of operation offered to Medicaid Members will be no less than those offered to commercial Members
- Not be excluded, penalized, or terminated from participating with Western Sky Community Care for having developed or accumulated a substantial number of patients in the Western Sky Community Care with high cost medical conditions
- Coordinate and cooperate with other service providers who serve Medicaid Members, such as Head Start Programs, Healthy Start Programs, Nurse Family Partnerships, and school based programs as appropriate
- Object to providing relevant or medically necessary services on the basis of the provider's moral or religious beliefs or other similar grounds
- Disclose to Western Sky Community Care, on an annual basis, any physician incentive plan (PIP) or risk arrangements the provider or provider group may have with physicians either within its group practice or other physicians not associated with the group practice even if there is no substantial financial risk between Western Sky Community Care and the physician or physician group
- Provide services in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in the Participating Provider Agreement
- Allow Western Sky Community Care direct access (not via vendor) to medical records for the purpose of data collection initiatives, such as HEDIS and other contractual, regulatory or other programs
- Review and follow clinical practice guidelines distributed by Western Sky Community Care

- Document Medical chart with up to three reach out attempts via phone to Members who have not completed an office visit in the past 12 month or more
  - Have been discharged from an inpatient-stay within the last 24 hours since notification
  - Have a gap-in-care overdue by 30 or more days
- Develop report based on Western Sky Community Care specification to submit monthly clinical data feed from the Electronic Medical Record (EMR) system within one year of enrolling in the Western Sky Community Care Provider Network
- Comply with New Mexico Risk Adjustment programs rely on complete and accurate diagnosis coding and reporting according to the ICD-10-CM coding guidelines
- Providers must allow for and process voluntary payroll deductions of fringe benefits or wage supplements for any employee who requests it, in accordance with the Wage Payments and Collection Law (43 P.S. §§ 260.2a and 260.3).
- Report all suspected physical and/or sexual abuse and neglect
- Report Communicable Disease to Western Sky Community Care:
  - Western Sky Community Care must work with DHS State and District Office epidemiologists in partnership with the designated county or municipal health department staffs to appropriately report reportable conditions

MEMBER GRIEVANCE AND APPEALS PROCESS

A Member, or Member authorized representative or a Member's Provider (with written consent from the Member), may file an appeal for payment issues and/or utilization management or general grievance either verbally or in writing.

Western Sky Community Care gives Members reasonable assistance in completing all forms and taking other procedural steps of the Appeal and Grievance process, including, but not limited to, providing translation services, communication in alternative languages and toll-free numbers with TTY/TDD and interpreter capability.

Western Sky Community Care values its providers and will not take punitive action, including and up to termination of a provider agreement or other contractual arrangements, for providers who file an Appeal or Grievance on a Member's behalf. Western Sky Community Care provides assistance to both Members and Providers with filing a Appeal or Grievance by contacting our Member and Provider Services Department at

Grievances

Grievances are spoken or written expressions of dissatisfaction given to Western Sky Community Care by a member or his/her authorized representative. These complaints can be about any action of Western Sky Community Care or a provider in our network. Complaints include, but are not limited to:

- Quality of care
- Personal behavior like rudeness of a provider or employee
- Failure to respect a member's rights
- Harmful administrative processes or operations

Western Sky Community Care wants to resolve member concerns. We will not hold it against the member if he/she files a grievance. We will not treat members differently.

How to File a Grievance

A member can file a grievance in any way that works best for them. They can:

- Call Member Services. The phone number is 1-844-543-8996 (TDD/TTY: 711).
- Use the member portal on our website: www.WesternSkyCommunityCare.com
- Send a fax. The fax number is 1-844-235-6050.
- Give it to us in person or by mail:

Western Sky Community Care
ATTN: Grievances
5300 Homestead Road NE
Albuquerque, NM 87110

Be sure to include:

- Member first and last name

- Member Centennial Care Medicaid ID number
- Member address and telephone number
- What the member is unhappy with
- What the member would like to have happen

Within five business days of receiving a member grievance, we will send the member a letter so the member knows we received it.

If someone else is going to file a grievance for a member, we must have written permission for that person to file a grievance for the member. No one can act on a members behalf without written permission.

To give them permission there is a *Personal Appeal Representation Form*. It is in the Forms section of this book and on our website. Members can also call Member Services. This form can be used to give the right to file a members grievance or appeal to someone else.

A member may have proof or information supporting his/her grievance. If so, please send it to us so we can add it to our information. Members can ask to get copies of any documentation Western Sky Community Care used to make the decision about a member's grievance, free of charge. We will resolve a member's grievance as quickly as a member's situation needs us to. If a member believes the situation is urgent please tell us. The member will get a letter from us within 30 calendar days that will tell him/her how we settled the concern.

We will not hold it against members if they file a grievance. We will not treat members differently in any way. We want to know members concerns so we can improve our services.

Appeals

An appeal is when a member asks us to review a decision made about his/her authorization. Members might want to appeal because a service has been denied, limited, reduced or ended. Appeals may be filed by a member (parent or guardian of a minor member). An appeal tells us to look at a denial again to make sure it was the right decision.

Members can appeal a decision that:

- Denies the care requested
- Authorizes a smaller amount of care
- Ends care that was approved previously
- Denies payment for care members may have to pay for

These types of decisions are called an "adverse benefit determination." If any of these actions occur, we will send the member a letter. The letter will explain what we decided and why we made that decision. It will also have information about member appeal rights.

If members want to file an appeal, members have to do it within 60 calendar days from the date of receipt of the adverse benefit determination letter.

Members can request copies of any documentation Western Sky Community Care used to make the decision about their care or appeal. Members can also request a copy of their member records. These copies will be free of charge.

We will not hold it against a member if he/she files an appeal. We will not treat members differently in any way.

How to File an Appeal

Members can file an appeal in any way that works best for them. They can:

- Call Member Services. The phone number is 1-844-543-8996 (TDD/TTY: 711).
- Send it electronically by fax. The fax number is 1-844-235-6050.
- Mail a letter.

Appeals for physical health and pharmacy services should be sent to:

Western Sky Community Care
ATTN: Appeals
5300 Homestead Road NE
Albuquerque, NM 87110

Appeals for physical health, behavioral health and pharmacy services should be sent to:

Western Sky Community Care
ATTN: Appeals
5300 Homestead Road NE
Albuquerque, NM 87110

After we receive a member call, written, or electronic appeal, we will send the member a letter within five business days. This will tell a member that we received it. If the appeal was received orally, we must receive a written appeal that is signed by the member within 13 calendar days. If a written appeal is not received in 13 days, the appeal will be considered withdrawn.

After we make a decision, we will send the member another letter. The member will have that decision within 30 days. If there is a reason we cannot decide within 30 days we may ask for an extension from New Mexico Human Services Department. We would have to tell them why we want the extension. We would have to show why the extension is in the member’s best interest.

Members can also request an extension if more time is needed. The extension would be 14 additional calendar days. If members want an extension, call Member Services and let them know the member is requesting an extension. The phone number is 1-844-543-8996 (TDD/TTY: 711).

Who May File an Appeal?

- The adult member

- The parent or guardian of a minor member
- A person named by member (member representative)
- A provider acting for a member

Members must give written permission for someone else to file an appeal for them. No one can speak for a member without his/her permission. There is a *"Personal Appeal Representative Form"* in our website: www.WesternSkyCommunityCare.com. That will tell us that the member gave someone this permission to appeal for him/her. Member's also will get a copy of this form with adverse benefit determination letters.

The Personal Appeal Representative Form must be sent in with the appeal. We have to receive it within 60 days from the date of receipt of the adverse benefit determination letter.

If a member needs help filing an appeal, call Member Services. The phone number is at 1-844-543-8996 (TDD/TTY: 711). We have people to help members Monday through Friday, 8:00 a.m. to 5:00 p.m. MT.

Continuing to Receive Services

Members can ask to keep receiving care while we review the appeal. Members must ask within 10 days after receiving the adverse benefit determination letter.

IMPORTANT: If the appeal finds our decision was right, members may have to pay for the service.

Fast Appeal Decisions

If a member's medical condition is urgent, we can make a decision about the appeal much faster. A member may need a fast decision if not getting the treatment will cause:

- Risk of serious health problems or death
- Serious problems with heart, lungs, or other body parts
- Member going into a hospital
- Member's doctor must agree that the member has an urgent need

If a member thinks he/she needs a fast appeal decision call Member Services. The phone number is 1-844-543-8996 (TDD/TTY: 711). Our Medical Director will make a decision and we will let the member know within 72 hours.

State Fair Hearings

Member may disagree with an appeal decision. If that happens members may request a State Fair Hearing. This is an appeal that goes to New Mexico Human Services Department (HSD) instead of Western Sky Community Care. In a State Fair Hearing, HSD will make the final decision.

Members must complete the Western Sky Community Care appeals process before they can request a State Fair Hearing. After we have finished a member appeal, we will send the member a letter. Members have 90 days from the date on the letter to ask for a State Fair Hearing.

Members can ask to keep receiving care during the State Fair Hearing process.

IMPORTANT: If the State Fair Hearing finds our decision was right, members may have to pay for the service.

Requests for a State Fair Hearing can be submitted in writing or online. Submit requests to:

New Mexico Human Services Department
Fair Hearings Bureau
P.O. Box 2348
Santa Fe, NM 87504
Email: HSD-FairHearings@state.nm.us
Call: (505) 476-6213
Toll Free: 1-800-432-6217 (option 6)
Fax: (505) 476-6215

For more information about the State Fair Hearing process, contact New Mexico Human Services Department Fair Hearings Bureau.

PROVIDER GRIEVANCES AND APPEALS

Western Sky Community Care maintains written policies and procedures for the filing of provider Grievances and Appeals. A provider has the right to file a Grievance or an Appeal with the us. Provider Grievances or Appeals shall be resolved within thirty (30) Calendar Days. If the provider Grievance or Appeal is not resolved within thirty (30) Calendar Days, we shall request a fourteen (14) Calendar Day extension from the provider. If the provider requests the extension, the extension shall be approved by us. A provider shall have the right to file an Appeal with us regarding provider payment issues and/or Utilization Management decisions.

Providers may file a Provider grievance regarding WSCC policies, procedures, or any aspect of WSCC administrative functions other than administrative review matters, including the process by which WSCC handles Notice of Proposed Actions and EOPs in addition to dissatisfaction with the resolution of the Provider's informal claims adjustment/claim grievance. Provider grievances may be filed verbally/telephonically, or in writing. Administrative review matters should be addressed following the procedcures outlined in the Member Appeals section of this manual.

Western Sky Community Care wants to resolve provider concerns. We will not hold it against the provider if he/she files a grievance. We will not treat providers differently.

How to File a Grievance

A provider can file a grievance in any way that works best for them. They can:

- Call Provider Services. The phone number is 844-738-5019 (TDD/TTY: 711).
- Send a fax. The fax number is 844-853-2480.
- Give it to us in person or by mail:

Western Sky Community Care
ATTN: Grievances and Appeals
5300 Homestead Road NE
Albuquerque, NM 87110

How to file an Appeal

A Provider Appeal is the request for review of a claim (Post Service) or any adverse determination prior to rendering a requested service or procedure (Pre-Service).

Examples include but are not limited to:

- Incorrect amount of claim payed
- Authorization related claim denial
- Contract related claim denial
- Partial payment of a claim

Provider Appeals must be received no later than 60 days from the Notice or Action or Explanation of Payment (EOP) or the appeal will be denied for timely filing.

Provider Appeals can be received by Mail, Fax, or Online Portal. An "Appeal Request" form NM Provider Appeal Form must be accompanied by any request for appeal. Send all appeal requests to:

Western Sky Community Care Healthplan
P.O. Box 5090
Farmington, MO 63640-5090

Provider Appeals will be resolved as soon as possible but no later than 30 calendar days from the day Western Sky Community Care receives the initial appeal request.

WASTE, FRAUD AND ABUSE

Western Sky Community Care takes the detection, investigation, and prosecution of fraud, waste, and abuse very seriously, and has a Fraud, Waste, and Abuse (FWA) program that complies with New Mexico and federal laws. Western Sky Community Care, successfully operates a Special Investigations Unit (SIU). Western Sky Community Care performs front and back end audits to ensure compliance with billing regulations. Our sophisticated code editing software performs systematic audits during the claims payment process. To better understand this system; please review the Billing and Claims Manual located on our website. Western Sky Community Care performs retrospective audits which in some cases may result in taking actions against those providers who, individually or as a practice, commit fraud, waste, and/or abuse. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Civil and/or criminal prosecution
- Onsite Investigations
- Corrective Action Plan
- Any other remedies available to rectify

Western Sky Community Care instructs and expects all its contractors and subcontractors to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Qui Tam Provisions (Whistleblower)
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Law)
- HIPAA
- Social Security Act
- US Criminal Codes

Western Sky Community Care requires all its contractors and subcontractors to report violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all Western Sky Community Care Members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, health care fraud, obstruction of a state and/or federal health care fraud investigation, money laundering, failure to provide medically necessary services, marketing schemes, prescription forging or altering, physician illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are

not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or Members' medication fraud.

FWA Training is available via our company website – we have a training program providers can download in PDF format. We also include FWA training in our Provider Orientation packets.

To report any Fraud, Waste and Abuse concerns please call the Fraud and Abuse Line at 1-866-685-8664.

Post-Processing Claims Audit

A post-processing claims audit consists of a review of clinical documentation and claims submissions to determine whether the payment made was consistent with the services rendered. To start the audit, Western Sky Community Care Auditors request medical records for a defined review period. Providers have two weeks to respond to the request; if no response is received, a second and final request for medical records is forwarded to the Provider. If the Provider fails to respond to the second and final request for medical records, or if services for which claims have been paid are not documented in the medical record, Western Sky Community Care will recover all amounts paid for the services in question.

Western Sky Community Care Auditors review cases for common FWA practices including:

- Unbundling of codes
- Up-coding services
- Add-on codes billed without primary CPT
- Diagnosis and/or procedure code not consistent with the member's age/gender
- Use of exclusion codes
- Excessive use of units
- Misuse of benefits
- Claims for services not rendered

Western Sky Community Care Auditors consider state and federal laws and regulations, Provider contracts, billing histories, and fee schedules in making determinations of claims payment appropriateness. If necessary, a clinician of like-specialty may also review specific cases to determine if billing is appropriate. Auditors issue an audit results letter to each provider upon completion of the audit, which includes a claims report which identifies all records reviewed during the audit. If the Auditor determines that clinical documentation does not support the claims payment in some or all circumstances, Western Sky Community Care will seek recovery of all overpayments. Depending on the number of services provided during the review period, Western Sky Community Care may calculate the overpayment using an extrapolation methodology. Extrapolation is the use of statistical sampling to calculate and project overpayment amounts. It is used by Medicare Program Safeguard Contractors, CMS Recovery Audit Contractors, and Medicaid Fraud Control Units in calculating overpayments, and is recommended by the OIG in its Provider Self-Disclosure Protocol (63 Fed. Reg. 58,399; Oct. 30, 1998). To ensure accurate application of the extrapolated methodology, Western Sky Community Care uses RAT-STATS 2007 Version 2, the OIG's statistical software tool, to select random samples, assist in evaluating audit results, and calculate projected overpayments. Providers who contest the overpayment methodology or wish to calculate an exact overpayment figure may do so by downloading RAT STATS

and completing the extrapolation overpayment. Audit findings are reported to the New Mexico Office of Inspector Genreal and the Office of the Attorney General Medicaid Fraud Control Section.

Suspected Inappropriate Billing

If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential FWA hotline at 1-866-685-8664. Western Sky Community Care takes all reports of potential fraud, waste, and/or abuse very seriously and investigate all reported issues.

NOTE: Due to the evolving nature of fraudulent, wasteful, and abusive billing, Western Sky Community Care may enhance the FWA program at any time. These enhancements may include but are not limited to creating, customizing or modifying claim edits, upgrading software, modifying forensic analysis techniques, or adding new subcontractors to help in the detection of aberrant billing patterns.

Waste, Fraud, and Abuse Reporting

Providers may voluntarily disclose any suspected waste, fraud, or abuse using the tool on the HSD website:

http://www.hsd.state.nm.us/LookingForAssistance/Report_Fraud.aspx

QUALITY MANAGEMENT

Western Sky Community Care culture, systems and processes are structured around its mission to improve the health of all enrolled Members. The Quality Assessment and Performance Improvement (QAPI) Program utilizes a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of healthcare provided to all Members, including those with special needs.

This system provides a continuous cycle for assessing and analyzing the quality of care and service among plan initiatives including primary, secondary, and tertiary care, preventive health, acute and/or chronic care, dental healthcare, over and under-utilization, continuity and coordination of care, patient safety, and administrative and network services. This includes the implementation of appropriate interventions and designation of adequate resources to support the interventions. The system allows for systemic analysis and re-measurement of barriers to care, the quality of care, and utilization of services over time.

Western Sky Community Care recognizes its legal and ethical obligation to provide Members with a level of care that meets recognized professional standards and is delivered in the safest, most appropriate settings. To that end, we will provide for the delivery of quality care with the primary goal of improving the health status of Members.

Where the Member's condition is not likely to improve, Western Sky Community Care will implement measures to prevent any further decline in condition or deterioration of health status or provide for comfort measures as appropriate and requested by the Member. This will include the identification of Members at-risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the interventions.

Whenever possible, the Western Sky Community Care QAPI Program supports these processes and activities that are designed to achieve demonstrable and sustainable improvement in the health status of Members.

Program Structure

The Western Sky Community Care Board of Directors (BoD) has the ultimate authority and accountability for the oversight of the quality of care and service provided to Members. The BoD oversees the QAPI Program and has established various committees and ad-hoc committees to monitor and support the QAPI Program.

The Quality Improvement Committee (QIC) is a senior management committee with Western Sky Community Care network physician representation that is directly accountable to the Board of Directors. The purpose of this committee is to provide oversight and direction in assessing the appropriateness and to continuously enhance and improve the quality of care and services provided to Members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the Quality and Medical Management programs.

The following committees report directly to the Quality Management Committee (QIC):

- Utilization Management Committee (UMC)
- Pharmacy &Therapeutics Committee (P&T)
- Credentialing Committee (CC)
- Performance Improvement Team
- Joint Operations Committee
- HEDIS Steering Committee
- Peer Review Committee

In addition to the committees reporting to the QIC, Western Sky Community Care has sub-committees and workgroups that report to the above committees including, but not limited to:

- Grievance and Appeals Committee
- Provider Advisory Committee
- Member Advisory Committee
- Hospital Advisory Committee
- Community Advisory Committee
- Ad-hoc committees may also include *regional level* committees for Member Advisory and/or Community Advisory based on distribution of membership.

Provider Involvement

Western Sky Community Care recognizes the integral role practitioner involvement plays in the success of its QAPI Program. Practitioner involvement in various levels of the process is highly encouraged through Provider representation and participation on the Quality Committees. Western Sky Community Care encourages PCP, specialty, OB/GYN, Pharmacy, LTSS and Behavioral Health representation on key quality committees including, but not limited to, the QIC, UMC, P&T, Credentialing, Provider and Member Advisory, as well as select ad-hoc committees.

Quality Assessment and Performance Improvement Program

Scope

The scope of the QAPI Program is comprehensive and addresses both the quality of clinical care and the quality of service provided to Western Sky Community Care Members. Western Sky Community Care's QAPI Program incorporates all demographic groups, care settings, and services in quality improvement activities, including preventive care, primary care, specialty care, acute care, short-term care, ancillary services, and operations.

Goals

Western Sky Community Care primary QAPI Program goal is to improve Members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving quality of care and services delivered.

The Western Sky Community Care QAPI Program monitors the following:

- Acute and chronic care coordination
- Behavioral health care
- Compliance with member confidentiality laws and regulation
- Compliance with preventive health guidelines and clinical practice guidelines
- Continuity and coordination of care
- Delegated entity oversight
- Department performance and service
- Employee and provider cultural competency
- Marketing practices
- Member enrollment and disenrollment
- Member Grievance System
- Member experience
- Patient safety
- Primary Care Provider changes
- Pharmacy
- Provider and Plan after-hours telephone accessibility
- Provider appointment availability
- Provider Complaint System
- Provider network adequacy and capacity
- Provider experience
- Selection and retention of providers (credentialing and recredentialing)
- Utilization Management, including over- and under-utilization

Patient Safety and Quality of Care

Patient Safety is a key focus of Western Sky Community Care QAPI Program. Monitoring and promoting patient safety is integrated throughout many activities across the plan, but primarily through identification of potential and/or actual quality of care events. A potential quality of care issue is any alleged act or behavior that may be detrimental to the quality or safety of patient care, is not compliant with evidence-based standard practices of care or that signals a potential sentinel event, up to and including death of a Member.

Western Sky Community Care employees (including Medical Management staff, Member Services staff, Provider Services, Appeal Coordinators, etc.), panel practitioners, facilities or ancillary Providers, Members or Member representatives, Medical Directors or the BoD may advise the Quality Management (QM) Department of potential quality of care issues. Adverse events may also be identified through claims-based reporting. Potential quality of care issues require investigation of the factors surrounding the event in order to make a determination of their severity and need for corrective action up to and including review by the Peer Review Committee as indicated.

Potential quality of care issues received in the QI department are tracked and monitored for trends in occurrence, regardless of their outcome or severity level.

Performance Improvement Process

Western Sky Community Care QIC reviews and adopts an annual QAPI Program and Work Plan aligned with Western Sky Community Care vision and goals and appropriate industry standards. The QM Department implements quality/risk/utilization management approaches to problem identification with the objective of identifying improvement opportunities. Most often, initiatives are selected based on data that indicates the need for improvement in a particular clinical or non-clinical area, and includes targeted interventions that have the greatest potential for improving member health outcomes, quality of access to care and services.

Performance improvement projects, focused studies and other QI initiatives are designed and implemented in accordance with principles of sound research design and appropriate statistical analysis. Results of these studies are used to evaluate the appropriateness and quality of care and services delivered against established standards and guidelines for the provision of that care or service. Each performance improvement initiative is also designed to allow Western Sky Community Care to monitor improvement over time. Quality Performance Measures have been identified based on the potential to improve health care for Western Sky Community Care Members. The measures are physical health focused HEDIS measures, integrated behavioral health care, HEDIS measures, along with identified state metrics. Performance is measured against established benchmarks and progress to performance goals.

Annually, Western Sky Community Care develops a QAPI Work Plan for the upcoming year. The QAPI Work Plan serves as a working document to guide quality improvement efforts on a continuous basis. The work plan integrates QIC activities, reporting, and studies from all areas of the organization (clinical and service). It also includes timelines for completion and reporting to the QIC and requirements for external reporting. Studies and other performance measurement activities and issues to be tracked over time are scheduled in the QAPI Work Plan.

Western Sky Community Care communicates activities and outcomes of its QAPI Program to both Members and Providers through avenues such as the Member newsletter, Provider newsletter, and the Western Sky Community Care web portal at https://www.westernskycommunitycare.com.

At any time, Western Sky Community Care Providers may request additional information on the Health Plan programs, including a description of the QAPI Program and a report on Western Sky Community Care progress in meeting the QAPI Program goals, by contacting the Quality Improvement department.

Feedback on Provider Specific Performance

As part of the quality improvement process, performance data at an individual Provider, practice or site level is reviewed and evaluated. This performance data may be used for quality improvement activities, including use by Western Sky Community Care quality committees (Quality Improvement Committee, Utilization Management Committee, Credentialing Committee, Performance Improvement Committee and/or other committees involved in the quality program). This review of provider specific performance data may include, but is not limited to:

- Site evaluation results including medical record audit, appointment availability, after-hours access, cultural proficiency, and in-office waiting time.
- Preventive care, including wellness exams, immunizations, prenatal care, lead screening, cervical cancer screening, breast cancer screening, and other age appropriate screenings for detection of chronic diseases or conditions.
- Member appeal and grievance data.
- Utilization management data including emergency room visits/1000 and bed days/1000 reports.
- Critical Incident reporting, sentinel events and adverse outcomes.
- Compliance with clinical practice guidelines.
- Pharmacy data including use of generics or specific drugs.

As part of its motivational incentive strategies, WSCC systematically profiles the quality of care delivered by high-volume PCPs to improve provider compliance with preventive health and clinical practice guidelines and clinical performance indicators. The profiling system is developed with network providers to ensure the process has value to providers, members and WSCC, and may include a financial component

Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA), which allows comparison across Health Plans. HEDIS gives purchasers and consumers the ability to distinguish between Health Plans based on comparative quality instead of simply cost differences. HEDIS reporting is a required part of NCQA Health Plan Accreditation and the New Mexico Human Services Department.

As both New Mexico and Federal governments move toward a healthcare industry that is driven by quality, HEDIS rates are becoming more and more important, not only to the Health Plan, but to the individual provider. New Mexico purchasers of healthcare use the aggregated HEDIS rates to evaluate the effectiveness of a Health Insurance Company's ability to demonstrate an improvement in preventive health outreach to its members. Physician specific scores are being used as evidence of preventive care from primary care office practices. The rates then serve as a basis for physician incentive programs, such as "Pay for Performance." These programs pay providers an increased premium based on scoring of such quality indicators used in HEDIS.

How are HEDIS rates calculated?

HEDIS rates can be calculated in two ways: administrative data or hybrid data. Administrative data consists of claim and submitted to the Health Plan. Measures calculated using administrative data may include: annual mammogram, annual chlamydia screening, appropriate treatment of asthma, antidepressant medication management, access to PCP services, and utilization of acute and mental health services.

Hybrid rates consists of both administrative data and a sample of medical record data. Hybrid data requires review of a random sample of Member medical records to abstract data for services rendered that were not reported to the Health Plan through claims/encounter data. Accurate and timely claim/encounter data and submission of appropriate procedure and diagnosis codes can reduce the

necessity of medical record reviews (see Western Sky Community Care website and HEDIS brochure for more information on reducing HEDIS medical record reviews and improving your HEDIS scores). Measures typically requiring medical record review include: diabetic HbA1c, eye exam and nephropathy, controlling high blood pressure, cervical cancer screening, and prenatal care and postpartum care.

When Will the Medical Record Reviews (MRR) Occur for HEDIS?

Medical record review audits for HEDIS are usually conducted March through May each year. Western Sky Community Care QM representatives, or a national MRR vendor contracted to conduct the HEDIS MRR on Western Sky Community Care's behalf may contact you if any of your patients are selected in the HEDIS samples. Your prompt cooperation with the representative is greatly needed and appreciated.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Western Sky Community Care which allows them to collect PHI on our behalf.

What can be done to improve my HEDIS scores?

- Understand the specifications established for each HEDIS measure.
- Submit claim/encounter data for each and every service rendered. All providers must bill (or report by encounter submission) for services delivered, regardless of contract status. Claim/encounter data is the most clean and efficient way to report HEDIS. If services are not billed or not billed accurately they are not included in the calculation. Accurate and timely submission of claim/encounter data will positively reduce the number of medical record reviews required for HEDIS rate calculation.
- Ensure chart documentation reflects all services provided.
- Bill CPT II codes related to HEDIS measures such as, body mass index (BMI) calculations, eye exam results and blood pressure readings.

If you have any questions, comments, or concerns related to the annual HEDIS project or the medical record reviews, please contact the Quality Improvement Department at 844-738-5019.

MEDICAL RECORDS REVIEW

Western Sky Community Care Providers must keep accurate and complete medical records. Such records will enable Providers to render the highest quality healthcare service to Members. They will also enable Western Sky Community Care to review the quality and appropriateness of the services rendered. To ensure the Member's privacy, medical records should be kept in a secure location.

Western Sky Community Care requires Providers to maintain all records for Members for at least ten (10) years. See the Member Rights section of this handbook for policies on Member access to medical records. Western Sky Community Care may conduct medical record reviews for the purposes including, but not limited to, utilization review, quality management, medical claim review, and Member grievance/appeal investigation. Providers must meet 80% of the requirements for medical record keeping; elements scoring below 80% are considered deficient and in need of improvement. Western Sky Community Care will work with any physician or Provider who scores less than 80% to develop an action plan for improvement. Medical record review results are filed in the QI Department and shared with the Credentialing Department to be considered at the time of re-credentialing.

Required Information

Medical records mean the complete, comprehensive Member records including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's participating primary care physician or Provider, that document all medical services received by the Member, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable state rules and regulations, and signed by the medical professional rendering the services.

Providers must maintain complete medical records for members in accordance with the following standards:

- Member's name, and/or medical record number on all chart pages
- Personal/biographical data is present (i.e., employer, home telephone number, spouse, next of kin, legal guardianship, primary language, etc.)
- Prominent notation of any spoken language translation or communication assistance
- All entries must be legible and maintained in detail
- All entries must be dated and signed, or dictated by the provider rendering the care
- Significant illnesses and/or medical conditions are documented on the problem list and all past and current diagnoses
- Medication, allergies, and adverse reactions are prominently documented in a uniform location in the medical record; if no known allergies, NKA or NKDA are documented
- An appropriate history of immunizations is made in chart for adults
- Evidence that preventive screening and services are offered in accordance with Western Sky Community Care's practice guidelines
- Appropriate subjective and objective information pertinent to the Member's presenting appeal is documented in the history and physical
- Past medical history (for Members seen three or more times) is easily identified and includes any serious accidents, operations and/or illnesses, discharge summaries, and ER encounters

- Working diagnosis is consistent with findings
- Treatment plan is appropriate for diagnosis
- Documented treatment prescribed, therapy prescribed and drug administered or dispensed including instructions to the member
- Documentation of prenatal risk assessment for pregnant women or infant risk assessment for newborns
- Signed and dated required consent forms
- Unresolved problems from previous visits are addressed in subsequent visits
- Laboratory and other studies ordered as appropriate
- Abnormal lab and imaging study results have explicit notations in the record for follow up plans; all entries should be initialed by the primary care provider (PCP) to signify review
- Referrals to specialists and ancillary providers are documented including follow up of outcomes and summaries of treatment rendered elsewhere including family planning services, preventive services and services for the treatment of sexually transmitted diseases
- Health teaching and/or counseling is documented
- Appropriate notations concerning use of tobacco, alcohol and substance use (for members seen three or more times substance abuse history should be queried)
- Documentation of failure to keep an appointment
- Encounter forms or notes have a notation, when indicated, regarding follow-up care calls or visits. The specific time of return should be noted as weeks, months or as needed
- Evidence that the Member is not placed at inappropriate risk by a diagnostic or therapeutic problem
- Confidentiality of Member information and records protected
- Evidence that an Advance Directive has been offered to adults 18 years of age and older

Additionally the LTSS Comprehensive Medical and Service Record should contain:

- Medication Record and Person-Centered Service Plan (PCSP/IPoC), where applicable
- Provider Acknowledgement of PCSP

Nursing Facility records will also include:

- Substantiation of Preadmission Screening and Resident Review (PASRR)
- Documentation of specialized services delivery
- Evidence of education regarding Patient Rights and Responsibilities
- Acknowledgement that the Member was informed of any patient pay liability
- Documentation of financial eligibility including audit of personal assets and authentication of known personal care accounts
- Other processes identified by either Western Sky Community Care or the Department.

Medical Records Release

All Member medical records shall be confidential and shall not be released without the written authorization of the covered person or a responsible covered person's legal guardian. When the release

of medical records is appropriate, the extent of that release should be based upon medical necessity or on a need to know basis.

As a reminder, protected health information (PHI) that is used or disclosed for purposes of treatment, payment or healthcare operations is permitted by HIPAA Privacy Rules (45 CFR 164.506) and does not require consent or authorization from the Member/patient. The MRR vendor will sign a HIPAA compliant Business Associate Agreement with Western Sky Community Care which allows them to collect PHI on our behalf.

Medical Records Transfer for New Members

All PCPs are required to document in the Member's medical record attempts to obtain historical medical records for all newly assigned Western Sky Community Care members. If the Member or member's guardian is unable to remember where they obtained medical care, or they are unable to provide addresses of the previous providers then this should also be noted in the medical record.

REGULATORY MATTERS

Section 1557 of the Patient Protection and Affordable Care Act

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Section 1557 builds on long-standing and familiar Federal civil rights laws: Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. Section 1557 extends nondiscrimination protections to individuals participating in:

- Any health program or activity any part of which received funding from HHS
- Any health program or activity that HHS itself administers
- Health Insurance Marketplaces and all plans offered by issuers that participate in those Marketplaces

For more information please visit http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html