TITLE 8 SOCIAL SERVICES
CHAPTER 315 OTHER LONG TERM CARE SERVICES
PART 2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.315.2.1 ISSUING AGENCY: New Mexico Health Care Authority.
[8.315.2.1 NMAC - Rp 8.315.2.1 NMAC, 7/1/2024]

8.315.2.2 SCOPE: The rule applies to the general public.
[8.315.2.2 NMAC - Rp 8.315.2.2 NMAC, 7/1/2024]

8.315.2.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended, and by the state health care authority pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991). Section 9-8-1 et seq. NMSA 1978 establishes the health care authority (HCA) as a single, unified department to administer laws and exercise functions relating to health care facility licensure and health care purchasing and regulation.
[8.315.2.3 NMAC - Rp 8.315.2.3 NMAC, 7/1/2024]

8.315.2.4 DURATION: Permanent.
[8.315.2.4 NMAC - Rp 8.315.2.4 NMAC, 7/1/2024]

8.315.2.5 EFFECTIVE DATE: July 1, 2024, unless a later date is cited at the end of a section.
[8.315.2.5 NMAC - Rp 8.315.2.5 NMAC, 7/1/2024]

8.315.2.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[8.315.2.6 NMAC - Rp 8.315.2.6 NMAC, 7/1/2024]

8.315.2.7 DEFINITIONS: [**RESERVED**]

8.315.2.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[8.315.2.8 NMAC - Rp 8.315.2.8 NMAC, 7/1/2024]

8.315.2.9 PACE PROGRAM SERVICES: The New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including services furnished in nursing facilities. To help New Mexico recipients receive necessary services, the New Mexico medical assistance division (MAD) pays for capitated and community-based services through the PACE program. This project provides a complete package of acute, long term care, personal care and social services to a frail population that meets nursing facility clinical criteria. See Section 9412(b) of the federal Omnibus Budget Reconciliation Act of 1986 and Section 1915(a) of the Social Security Act. This part describes the following: eligible providers, services for recipients who are nursing home eligible, covered services, service limitations, and reimbursement methodology.
[8.315.2.9 NMAC - Rp 8.315.2.9 NMAC, 7/1/2024]

8.315.2.10 ELIGIBLE PROVIDERS:

A. The eligible provider will have a professional services agreement (PSA) with the HCA. The provider will also meet the following conditions:

(1) be licensed and certified by the licensing and certification bureau of the department of health (DOH) to meet conditions as a diagnostic and treatment center;

(2) participate in the MAD utilization review process and agree to operate in accordance with all policies and procedures of that system; and

(3) meet and comply with the centers for medicare and medicaid services (CMS) requirements for full provider status for PACE organizations.

B. Once enrolled, the provider will receive a packet of information, including medicaid program policies, utilization review instructions, and other pertinent material from MAD. The provider is responsible for ensuring receipt of these materials and for updating as new materials are received from MAD.
[8.315.2.10 NMAC - Rp 8.315.2.10 NMAC, 7/1/2024]

8.315.2.11 PROVIDER RESPONSIBILITIES:

A. The provider who furnishes services to medicaid recipients will comply with all specified medicaid participation requirements. See 8.302.1 NMAC, *General Provider Policies*. The provider will verify that individuals are eligible for medicaid, medicare, or other health insurance at the time services are furnished. The provider will verify whether or not an individual is self-pay at the time services are provided. The provider will maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See 8.302.1 NMAC, *General Provider Policies*. The provider will provide the coordination which will enable the client to utilize PACE as the single source for primary care. This will assist the enrollee in the coordination of care by specialists.

B. Outreach and marketing: The provider will have a written plan which accomplishes the following outreach and marketing objectives.

(1) Strategies of how prospective participants are provided adequate program descriptions.

(a) The program descriptions shall be written in a culturally competent format at a language level understandable by the participant (sixth grade). The format should be sensitive to the culture and language common to the service area.

(b) Program descriptions should include the services available through the program. The services include, but are not limited to, the following: enrollment and disenrollment, procedures to access services, after hours call-in system, provisions for emergency treatment, restrictions against using medical providers or services not authorized by the interdisciplinary team, and any other information necessary for prospective participants to make informed decisions about enrollment. Prior to enrollment, each participant will be informed of what individualized initial assessment and treatment plan has been developed by the interdisciplinary team.

(2) Development of outreach and enrollment materials (including marketing brochures, enrollment agreements, website and disenrollment forms). These materials should be submitted in draft form to MAD for approval prior to publication. Distribution prior to approval is prohibited.

(3) Submit an active and ongoing marketing plan, with measurable enrollment objectives and a system for tracking its effectiveness. The plan shall also include, but not be limited to, the sequence and timing of promotional and enrollment activities and the resources needed for implementation.

(4) Ensure that prohibited marketing activities are not conducted by its employees or its agents. Prohibited practices are:

(a) discrimination of any kind while maintaining the PACE program requirements;

(b) statements or activities that could mislead or confuse potential participants, or misrepresent the contractor, CMS, or the state medicaid agency;

(c) inducing enrollment through gifts or payments; the Procurement Code, Sections 13-1-28 through 13-1-199 NMSA 1978, imposes civil and misdemeanor criminal penalties for its violation; in addition, the New Mexico criminal statutes impose felony penalties for bribes, gratuities and kickbacks; and

(d) subcontracting outreach efforts to individuals or organizations whose sole responsibility involves direct contact with elderly to solicit enrollment.
[8.315.2.11 NMAC - Rp 8.315.2.11 NMAC, 7/1/2024]

8.315.2.12 ELIGIBLE RECIPIENTS: Medicaid recipients who meet the eligibility requirements as stated in the medical assistance division eligibility manual may be eligible to participate in the PACE program.
[8.315.2.12 NMAC - Rp 8.315.2.12 NMAC, 7/1/2024]

8.315.2.13 COVERED SERVICES: The PACE program is a partially capitated, community-based service program. The PACE program will ensure access to a comprehensive benefit package of services to a frail population that meets nursing facility clinical criteria. The provider will provide all medicaid services that are included in a capitated rate. Medicare covered services will be reimbursed through a medicare capitated rate. The provider will provide medicare-eligible PACE participants with all medicare services that are included in the medicare capitated rate. Effective Janaury 1, 2006, upon the implementation of medicare part D prescription drug coverage, pharmacy costs for PACE medicare beneficiaries are covered by the medicare capitated rate. Pharmacy costs for medicaid only recipients would be covered by the medicaid only capitated rate.

A. Adult day health center: The focal point for coordination and provision of the majority of the PACE program services is the adult day health center. The adult day health center will include a primary care clinic and areas for therapeutic recreation, restorative therapies, socialization, personal care and dining. The center shall include the following areas:

(1) examination room(s);
(2) treatment room(s);
(3) therapy room(s);
(4) dining room(s);
(5) activity room(s);
(6) kitchen;
(7) bathroom(s);
(8) personal care room(s);
(9) administrative office(s);
(10) counseling office(s);
(11) pharmacy/medication room; and
(12) laboratory;

B. Interdisciplinary team: The interdisciplinary team is a critical element of the PACE program. The ongoing process of service delivery in this model requires the team to identify participant problems, determine appropriate treatment objectives, select interventions and evaluate efficiencies of care on an individual participant basis. The interdisciplinary team is composed of, but not limited to, the following members: Primary care physician, nurse, dietician, social worker, physical therapist, occupational therapist, speech therapist, recreational therapist or coordinator, day health center supervisor, home care liaison, health workers/aides, and drivers. Some of the interdisciplinary team members may be project staff and some may be contracted positions. All members must meet applicable state licensing and certification requirements and provide direct care and services appropriate to participant need.

C. Benefit package: The benefit package includes the following:

(1) a service delivery system that ensures prompt access to all covered services, including referral protocols, approved by the interdisciplinary team;

(2) access to medical care and other services, as applicable, 24 hours per day, seven days a week, 365 days per year; all care and services shall be available and shall be provided at such times and places, including the participants home or elsewhere, as are necessary and practical;

(3) access to an acute and comprehensive benefit package of services, including, but not limited to:

(a) interdisciplinary assessment and treatment planning;
(b) social work services;
(c) nutritional counseling;
(d) recreational therapy;
(e) meals;
(f) restorative therapies, including physical therapy, occupational therapy and speech therapy;
(g) home care (personal care, nursing care and disposable medical supplies), see 8.325.9 NMAC, *Home Health Services*;
(h) transportation, see 8.324.7 NMAC, *Transportation Services and Lodging*;
(i) drugs and biologicals; effective January 1, 2006, pharmacy costs are reimbursed by medicare for medicare beneficiaries; pharmacy costs for medicaid-only recipients are reimbursed by medicaid through the medicaid-only capitated rate; see 8.324.4 NMAC, *Pharmacy Services*, and Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*;
(j) prosthetics, medical supplies and durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures and repairs and maintenance for these items; see 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.310.6 NMAC, *Vision Care Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*;
(k) behavioral health services, 8.310.8 NMAC, *Mental Health Professional Services* and 8.315.3 NMAC, *Psychosocial Rehabilitation Services*;
(l) nursing facility services which include, but are not limited to, the following: semi-private room and board, physician and skilled nursing services, custodial care, personal care and assistance,

biologicals and drugs, physical, speech, occupational and recreational therapies, if necessary, social services, and medical supplies and appliances, see 8.312.2 NMAC, *Nursing Facilities*; 8.311.4 NMAC, *Outpatient Psychiatric Services and Partial Hospitalization*; 8.325.8 NMAC, *Rehabilitation Service Providers*; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*; and

(m) urgent care services.

(4) coordinating access for the following services:

(a) primary care services including physician and nursing services;

(b) medical specialty services, including but not limited to: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhino-laryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, surgery, thoracic and vascular surgery, urology; see 8.301.2 NMAC, *General Benefit Description*; 8.310.2 NMAC, *Medical Services Providers*; 8.311.2 NMAC, *Hospital Services*; 8.310.5 NMAC, *Anesthesia Services*; 8.324.6 NMAC, *Hearing Aids and Related Evaluations*; 8.310.7 NMAC, *Dental Services*; and 8.310.6 NMAC, *Vision Care Services*;

(c) laboratory and x-rays and other diagnostic procedures; see 8.324.2 NMAC, *Laboratory Services*;

(d) acute inpatient services, including but not limited to, the following: ambulance, emergency room care and treatment room services, semi-private room and board, general medical and nursing services, medical surgical/intensive care/coronary care unit as necessary, laboratory tests, x-rays and other diagnostic procedures, drugs and biologicals, blood and blood derivatives, surgical care, including the use of anesthesia, use of oxygen, physical, speech, occupational, and respiratory therapies, and social services; see 8.301.2 NMAC, *General Benefit Description*; 8.324.8 NMAC, *Prosthetics and Orthotics*; 8.324.10 NMAC, *Ambulatory Surgical Center Services*; and 8.310.5 NMAC, *Anesthesia Services*; 8.324.2 NMAC, *Laboratory Services*; 8.324.4 NMAC, *Pharmacy Services*; Subsection D of 8.310.2.12 NMAC, *Medical Services Providers*; 8.325.8 NMAC, *Rehabilitation Service Providers*; and

(e) hospital emergency room services.

(5) in-area emergency care; all medicaid reimbursable emergency services included in the capitated rate will be reimbursed by the PACE program to a non-affiliated provider when these services are rendered within the PACE program geographic service area; these emergency services will be reimbursed by the PACE program only until such time as the participant's condition permits travel to the nearest PACE program-affiliated facility;

(6) out-of-area emergency care that is provided in, or en route to, a hospital or hospital emergency room, in a clinic, or physician's office, or any other site outside of the PACE program service area; covered services included in the capitation rate will be paid by the PACE program when rendered in and out-of-area medical emergency, but only until such time as the participants condition permits travel to the nearest PACE program-affiliated facility.

[8.315.2.13 NMAC - Rp 8.315.2.13 NMAC, 7/1/2024]

8.315.2.14 NONCOVERED SERVICES:

A. The following services are not the responsibility of the provider or medicaid:

(1) any medicaid capitated or fee-for-service benefit which has not been authorized by the multidisciplinary team;

(2) in inpatient facilities, private room and private duty nursing, unless medically necessary, and non-medical items for personal convenience, such as telephone charges, radio, or television rental;

(3) cosmetic surgery unless required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy;

(4) experimental medical, surgical or other health procedures or procedures not generally available;

(5) care in a government hospital (veterans administration, federal/state hospital) unless authorized;

(6) service in any hospital for the treatment of chronic, medically uncomplicated drug dependency or alcoholism; and

(7) any services rendered outside of the United States.

B. The participant will be financially responsible for any of the above-mentioned services.

[8.315.2.14 NMAC - Rp 8.315.2.14 NMAC, 7/1/2024]

8.315.2.15 TREATMENT PLANS:

A. Prior to enrollment, an initial assessment and treatment plan for each participant is developed by the interdisciplinary team.

B. Each participant will be reassessed by the interdisciplinary team on a semi-annual basis and informed about a new treatment plan.

C. The enrollee, enrollees family, or representative shall be included in the initial assessment, treatment plan and semi-annual reassessment of the treatment plan.

[8.315.2.15 NMAC - Rp 8.315.2.15 NMAC, 7/1/2024]

8.315.2.16 ENROLLMENT OF PARTICIPANTS:

A. The effective date for the recipient's enrollment in the program is the first day of the calendar month following the signing of the enrollment agreement, if an approved level of care (LOC) and all financial and non-financial eligibility criteria have been approved by the income support division (ISD).

B. The potential participant signs an enrollment agreement which includes, but is not limited to, the following information:

(1) enrollment and disenrollment data that will be collected and submitted to the HCA, including, but not limited to, the following:

(a) social security number;

(b) health insurance claim number (HIC);

(c) last name, first name, middle initial;

(d) date of birth;

(e) address of current residence;

(f) assigned ISD office address;

(g) medicare number (part A and part B) for medicare beneficiaries;

(h) medicaid number; and

(i) effective date of enrollment in the PACE program;

(2) benefits available, including all medicare and medicaid covered services, and how services are allocated or can be obtained from the PACE program provider, including, but not limited to:

(a) appropriate use of the referral system;

(b) after hours call-in system;

(c) provisions for emergency treatment;

(d) hospitals to be used; and

(e) the restriction that enrollees may not seek services or items from medicaid and medicare providers without authorization from the interdisciplinary team;

(3) participant premiums and procedures for payment, if any; this includes the medical care credit if the participant enters a nursing home;

(4) participant rights, grievance procedures, conditions for enrollment and disenrollment and medicare and medicaid appeal processes;

(5) participants obligation to notify the PACE program provider of a move or absence from the providers service area;

(6) procedures to assure that applicants understand that all medicaid services must be received through the PACE program provider (the "lock-in" provision);

(7) procedures for obtaining emergency services and urgent care;

(8) statements that the PACE program provider has a program agreement with CMS and the state medicaid agency that may be subject to periodic renewal, and that termination of that agreement may result in termination of enrollment in the PACE program; statement that the PACE program provider and the state medicaid agency enter into a contract, which must be periodically renewed, and that failure to renew the contract may result in termination of enrollment in the PACE program;

(9) participants authorization for the disclosure and exchange of information between CMS, its agent, the state medicaid agency and the PACE program provider; and

(10) participant's signature and date.

C. Once the participant signs the enrollment agreement, the participant receives the following:

(1) a copy of the enrollment agreement;

(2) participant/provider contract or evidence of coverage, if this is different from the enrollment agreement;

(3) a PACE program membership card; and

(4) an emergency sticker to be posted in the participants home in case of emergency.

D. The provider will inform the participant and the ISD office when enrollment is completed.

E. Enrollment and services continue unless eligibility of recipient changes or until the participant either voluntarily disenrolls or involuntary disenrollment occurs as described below.

[8.315.2.16 NMAC - Rp 8.315.2.16 NMAC, 7/1/2024]

8.315.2.17 DISENROLLMENT OF PARTICIPANTS: All voluntary and involuntary disenrollments will be documented and available for review by the state medicaid agency. The provider will inform the ISD office when a participant is being disenrolled either voluntarily or involuntarily. Disenrollment is effective by the first day of the second calendar month following the date in which enrollment has changed.

A. Voluntary disenrollment: A participant may begin the process of voluntary disenrollment at any time during the month. The provider shall use the most expedient process allowed by medicaid and medicare procedures while ensuring a coordinated disenrollment date. Until enrollment is terminated, the participants are required to continue using the PACE program services and remain liable for any premiums. The provider shall continue to provide all needed services until the date of termination.

B. Involuntary disenrollment: A participant may be involuntarily disenrolled if the participant:

(1) moves out of the PACE program service area;

(2) is a person with decision-making capacity who consistently does not comply with the individual plan of care and poses a significant risk to self or others;

(3) experiences a breakdown in the physician or team participant relationship such that the PACE program provider's ability to furnish services to either the participant or other participant(s) is seriously impaired;

(4) refuses services or is unwilling to meet conditions of participation as they appear in the enrollment agreement;

(5) refuses to provide accurate financial information, provides false information or illegally transfers assets;

(6) is out of the PACE program provider service area for more than 30 days (unless arrangements have been made with the PACE program provider);

(7) is enrolled in a PACE program that loses its contracts or licenses which enable it to offer health care services;

(8) ceases to meet the financial or non-financial criteria; and

(9) ceases to meet the level of care (LOC) at any time.

[8.315.2.17 NMAC - Rp 8.315.2.17 NMAC, 7/1/2024]

8.315.2.18 APPROPRIATE REFERRAL FOR OTHER SERVICES:

A. The provider will assist a participant who either voluntarily or involuntarily disenrolls from the PACE program to apply for other possible services, including medicare or private-pay services; and,

B. The provider will work with the state medicaid agency to ascertain the individual's potential eligibility for other medicaid categories.

[8.315.2.18 NMAC - Rp 8.315.2.18 NMAC, 7/1/2024]

8.315.2.19 PROVISIONS FOR REINSTATEMENT OF PARTICIPANTS TO THE PACE PROGRAM: There are no restrictions placed on a former participant's reinstatement into the PACE program, if the former participant continues to meet financial, non-financial and medical eligibility criteria.

[8.315.2.19 NMAC - Rp 8.315.2.19 NMAC, 7/1/2024]

8.315.2.20 REDETERMINATION: The ISD office will conduct a redetermination at least annually of all financial and non-financial criteria, per the standards of the medicaid eligibility requirements. See Subsection A of 8.280.600.12 NMAC, *Ongoing Benefits, Regular Reviews*. LOC is determined by the HCA's utilization review contractor.

[8.315.2.20 NMAC - Rp 8.315.2.20 NMAC, 7/1/2024]

8.315.2.21 PARTICIPANT RIGHTS: The provider will have written policies and procedures for ensuring the rights of participants as well as educating the participants to the PACE program. These policies and procedures

should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level) covering, at a minimum, the following:

A. the enrollment/disenrollment process;

B. services available through the program;

C. procedures to access services;

D. after hours call-in system;

E. provisions for emergency treatment; and

F. restrictions against using medical providers or services not authorized by the interdisciplinary team.

[8.315.2.21 NMAC - Rp 8.315.2.21 NMAC, 7/1/2024]

8.315.2.22 GRIEVANCE PROCEDURES: The provider will have participant grievance procedures which provide the participants and their family members with a process for expressing dissatisfaction with the program services, whether medical or nonmedical in nature. The procedures will explain and permit an orderly resolution of informal and formal grievances. These procedures should be presented in a culturally competent format at a language level understandable by the participant or their families (sixth grade level). The procedures will:

A. ensure that all provider grievance procedures and any subsequent changes are prior-approved by MAD in writing and included in the enrollment agreement;

B. ensure that a staff member is designated as having primary responsibility for the maintenance of the grievance procedures, review of their operation, and revision of related policies and procedures whenever necessary;

C. ensure that the grievance procedures clearly explain to participants which staff members are assigned to receive formal and informal complaints, the expected procedure, and the time frames for doing so;

D. ensure that a copy of the participant grievance procedures and complaint forms are available to participants;

E. ensure that procedures are in place for tracking, investigating, recording, resolving and appealing decisions concerning grievances made by participants or others; and

F. ensure there is no discrimination against a participant solely on the grounds the participant filed a grievance.

[8.315.2.22 NMAC - Rp 8.315.2.22 NMAC, 7/1/2024]

8.315.2.23 QUALITY ASSURANCE SYSTEM:

A. The provider will have a written plan of quality assurance and improvement which provides for a system of ongoing assessment, implementation, evaluation, and revision of activities related to overall program administration and services. The plan will:

(1) ensure that standards are incorporated into the provider policy and procedure manual; the provider standards will be based on the PACE protocol, applicable PACE standards and applicable licensing and certification criteria;

(2) ensure that goals and objectives provide a framework for quality improvement activities, evaluation and corrective action;

(3) ensure that quality indicators are objective and measurable variables related to the entire range of services provided by the PACE program provider; the methodology should assure that all demographic groups, all care settings, e.g., inpatient, the PACE program center and in-home, will be included in the scope of the quality assurance review;

(4) ensure that quality indicators are selected for review on the basis of high volume, high risk diagnosis or procedure, adverse outcomes, or some other problem-focused method consistent with the state of the art;

(5) ensure that the evaluation process or procedures review the effectiveness of the interdisciplinary team in its ability to assess participants care needs, identify the participant's treatment goals, assess effectiveness of interventions, evaluate adequacy and appropriateness of service utilization and reorganize treatment plan as necessary;

(6) establish the composition and responsibilities of a quality assurance committee and an ethics committee;

(7) ensure participant involvement in the quality assurance plan and evaluation of satisfaction with services; and

(8) designate an individual to coordinate and oversee implementation of quality assurance activities.

B. The quality assurance committee will hold quarterly meetings with the provider staff, including, but not limited to, the: 1) medical director; 2) interdisciplinary team; and, 3) administrative director. The provider will prepare quarterly written status reports for review at the quality assurance committee meetings. Written status reports will include, at a minimum, a discussion of project progress, problems encountered and recommended solutions, identification of policy or management questions, and requested project plan adjustments.

[8.315.2.23 NMAC - Rp 8.315.2.23 NMAC, 7/1/2024]

8.315.2.24 DATA GATHERING/REPORTING SYSTEM:

A. Standardized data: The provider will ensure the quality of the data according to MAD medium and frequency of reporting.

B. Software: The provider shall make no use of computer software developed pursuant to the contract, except as provided in the contract or as specifically granted in writing by the HCA.

[8.315.2.24 NMAC - Rp 8.315.2.24 NMAC, 7/1/2024]

8.315.2.25 FINANCIAL REPORTING: The provider is required to submit certain financial reports as follows.

A. A budgeted versus actual financial report for the current and year-to-date periods on a monthly basis 45 days after the end of each month. During the first year of operation, the financial report will be submitted on a monthly basis, 45 days after the end of each month. Thereafter, this report will be submitted on a quarterly basis, 45 days after the end of each quarter. The state medicaid agency reserves the right to extend the submission of this report on a monthly basis should provider performance indicate a need for more frequent monitoring.

B. Fiscal data based on cost center accounting structure provided by the state medicaid agency. At the twelfth month, the year-to-date summary will provide the necessary annual data.

C. Submit a cumulative report to the state medicaid agency in the form and detail described by On Lok senior health services/national PACE association. The interim cost report is due 45 days after the end of each providers fiscal quarter and covers the period from the beginning of the fiscal year through the respective quarter.

D. Submit to the state medicaid agency a cost report in the form and detail prescribed by the state medicaid program no later than 180 days after the end of the providers fiscal year.

E. Submit to the state medicaid agency a quarterly balance sheet for those PACE program providers that are separate corporate entities.

[8.315.2.25 NMAC - Rp 8.315.2.25 NMAC, 7/1/2024]

8.315.2.26 UTILIZATION REVIEW: All medicaid services, including services covered under the PACE program, are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. Prior authorization: To be eligible for the PACE program, a medicaid recipient must require a nursing facility level of care (LOC). Level of care determinations are made by MAD or its designee. The plan of care (POC) developed by the recipients interdisciplinary team must specify the type, amount and duration of service. Some services specified in the POC may require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. Eligibility determination: Prior authorization of service does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are financially and medically eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. Reconsideration: Providers who disagree with prior authorization request denials or other review decisions may request a re-review and a reconsideration. See MAD-953, *Reconsideration of Utilization Review Decisions* [8.350.2 NMAC].

[8.315.2.26 NMAC - Rp 8.315.2.26 NMAC, 7/1/2024]

8.315.2.27 REIMBURSEMENT: PACE program providers must submit claims for reimbursement on the UB 92 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

[8.315.2.27 NMAC - Rp 8.315.2.27 NMAC, 7/1/2024]

HISTORY OF 8.315.2 NMAC:

History of Repealed Material:
8 NMAC 4.MAD.777, Pre-PACE Pilot Project Services, filed 1/20/1998 - Repealed effective 12/1/2006.
8.315.2 NMAC, Program of All-Inclusive Care for the Elderly, filed 11/15/2006 - Repealed effective 7/1/2024.

Other: 8.315.2 NMAC, Program of All-Inclusive Care for the Elderly, filed 11/15/2006 Replaced by 8.315.2 NMAC, Program of All-Inclusive Care for the Elderly effective 7/1/2024.