3. Member Education

3.1. Policies and Procedures

The MCO shall maintain policies and procedures governing the development and distribution of educational material for members. Policies shall address how members and potential members receive information, the means of dissemination and the content comprehension level, and languages of this information. The MCO shall have written policies and procedures regarding the utilization of information on race, ethnicity, and primary language spoken by its membership.

All written Member materials shall meet the material guidelines established in the Agreement and defined in Section 11 Marketing of this Manual. All materials distributed shall include a language block informing the Member that the document contains important information and directs the Member to call the MCO to request the document in an alternative language or to have it orally translated at no expense to the Member. The language block shall be printed, at a minimum, in the non--English languages meeting the requirement of Subsection A of 8.308.8.10 NMAC.

MCOs shall provide members the option of receiving materials via mail, email, or website in accordance with 42 CFR 438.10. Member materials and enrollee information **may not** be provided electronically to the enrollee unless **all** of the following are met:

- The information is provided electronically after obtaining the enrollee's consent to receive the information electronically;
- The format is readily accessible;
- The information is placed in a location on the MCO's website that is prominent and readily accessible;
- The information is provided in an electronic form that can be electronically retained and printed;
- The information is consistent with the content and language requirements of Section 42 CFR 438.10; and
- The enrollee is informed the information is available in paper form without charge upon request and the MCO provides it upon request within 5 business days.

The MCO shall provide written notice to members of any material changes previously sent at least 30 calendar days before effective date of the change.

3.2. Member Handbook

The MCO Member handbook must include a table of contents and, at a minimum, comply with the following:

- MCO demographic information, including the organization's hotline telephone number and hours of operation;
- Information on how to obtain services such as after-hours and emergency services, including the 911 telephone system or its local equivalent, and Nurse Advice line;
- Member bill of rights and Member responsibilities, including any restrictions on the Member's freedom of choice among network providers;
- Information pertaining to coordination of care by and with PCPs (within the MCO), as well as information pertaining to transition of care (between the MCOs);
- How to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services;
- The amount, duration, and scope of mandatory benefits;
- Information on accessing BH or other specialty services, including a discussion of the Member's rights to self-refer to in-plan and out-of-plan family planning providers, a female Member's right to self-refer to a women's health specialist within the network for covered care, and that members may self-refer for BH services and are not required to visit their PCP first;
- Limitations to the receipt of care from out-of-network providers;
- A list of services for which prior authorization or a referral is required and the method of obtaining both;
- Information on Utilization Management (UM) Services;
- A policy on referrals for specialty care and other benefits not furnished by the Member's PCP;
- Information on how to obtain pharmacy services;
- Information regarding Grievances, Appeals, and Fair Hearing procedures and timeframes including all pertinent information provided in 42 CFR 438.00 through 438.424;
- Information on the Member's right to terminate enrollment and the process for voluntarily dis-enrolling from the plan;
- Information on the MCO switch process;
- Information on how members change their demographic information.

- Information regarding advance directives including advance directives for BH;
- Information regarding how to obtain a second opinion;
- Information on cost sharing, if any;
- How to obtain information, upon request, determined by HCA as essential during the Member's initial contact with the MCO, which may include a request for information (RFI) regarding the MCO's structure, operation, and physician's or senior staff's incentive plans;
- Value-added benefits which are not covered by the Agreement and how the Member may access those benefits;
- Information regarding the birthing option program;
- Language that clearly explains that a Native American Member may self-refer to an IHS or a tribal health care facility for services;
- Information on how to report fraud, waste and abuse;
- Information on Member's privacy rights;
- Information on the circumstance/situations under which a Member may be billed for services or assessed charges or fees; specifically that the provider may not bill a Member or assess charges or fees except: if a Member self-refers to a specialist or other provider within the network without following contractor procedures (e.g., without obtaining prior authorization) and the contractor denies payment to the provider, the provider may bill the Member, if a provider fails to follow the contractor's procedures, which results in nonpayment, the provider may not bill the Member, and if a provider bills the Member for noncovered services or for self-referrals, he or she shall inform the Member and obtain prior agreement from the Member regarding the cost of the procedure and the payment terms at time of service;
- Information on how to access services when out of state;
- Include information about Care Coordination, including the role of Care Coordinators; and
- Information on the centennial rewards program and how a Member accesses the program and earns rewards.

3.3. Provider Directories

The MCO may choose to maintain regionalized, printed, or printable provider directories by Northern, Southern, and Central regions of the State; however, each regionalized provider directory must include

telephone numbers for crisis lines, Member Services line, all out of state providers and Bernalillo County providers. Information on how to access these regionalized provider directories online or how to request a copy should be indicated on the MCO's website and in the Member Handbook.
Online provider directories must be comprehensive and inclusive of all providers in all regions, as well as telephone numbers for crisis lines, Member Services line, and all out of state providers.

3.4. Member Identification Card

The Member ID card shall be durable (e.g., plastic or other durable paper stock but not regular paper stock), shall comply with all State and Federal requirements and, at a minimum, shall include:

- The MCO's name and issuer identifier, with the company logo;
- Phone numbers for information and/or authorizations, including for physical health (PH), BH, and Long-Term Care (LTC) services;
- Descriptions of procedures to be followed for emergency or special services;
- The Member's identification number;
- The Member's name (first, last, and middle initial);
- The Member's date of birth;
- The Member's enrollment effective date;
- The Member's PCP;
- Whether the Member is enrolled in the Alternative Benefit Plan;
- The Member's State -issued Medicaid identification number. This number is the ten digit number supplied to the MCO in the nightly batch of Member information sent from HCA-; and
- All applicable co-payment amounts.

3.5. Member Advisory Board

The MCO shall convene and facilitate a Member Advisory Board and adhere to all requirements below. Member Advisory Board members shall serve to advise the MCO on issues concerning service delivery and quality of all Covered Services (e.g., BH, PH and LTC), Member rights and responsibilities, resolution of Member Grievances and Appeals and the needs of groups represented by Member Advisory Board members as they pertain to Medicaid.

The Member Advisory Board shall consist of Members (with representation of all Medicaid populations enrolled in the MCO), family Members, and providers. The MCO shall have an equitable representation of its Members in terms of race, gender, special populations, and New Mexico's geographic areas.

The MCO's Member Advisory Board shall keep a written record of all attempts to invite and include its Members in its meetings. The Member Advisory Board roster and minutes shall be made available to HCA 10 calendar days following the meeting date.
The MCO shall hold quarterly, centrally -located Member Advisory Board meetings throughout the term of the Agreement. The MCO shall advise HCA 10 calendar days in advance of meetings to be held.

In addition to the quarterly meetings, the MCO shall hold at least two additional statewide Member Advisory Board meetings each contract year that focus on Member issues to ensure Members' issues and concerns are heard and addressed. Attendance rosters and minutes for these two statewide meetings shall be made available to HCA within 10 calendar days following the meeting date.

The MCO shall ensure all Member Advisory Board Members actively participate in deliberations and that no one Board Member dominates proceedings in order to foster an inclusive meeting environment.