# New Mexico Human Services Department

Medical Assistance Division Managed Care Policy Manual

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1 GENERAL PROVISIONS

Revision Dates: January 1, 2014
Review Date: January 1, 2014
Initial Effective Date: January 1, 2014

The purpose for the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by HSD for the administration of the Medicaid managed care program and to provide direction to the managed care organizations (MCOs) and other entities providing service under managed care.

The Manual was developed by the Medical Assistance Division (MAD) of the New Mexico Human Services Division (HSD) to assist MCOs in the administration of the managed care program. These policies establish general operating procedures to assist in the day to day management of the managed care program. This Manual should be used as a reference and a general guide. It is a resource for interpreting the managed care Agreement and NMAC rules pertaining to managed care.

The following documents are incorporated into the Manual by reference: HSD MAD Request For Proposals and associated agreement dated August 31, 2012, and HSD Letters of Direction (LODs) issued to the Medicaid MCOs in 2013 and 2014. The provisions of the Manual reflect the general operating policies and essential procedures of the managed care program, are not all inclusive, and may be amended or revoked at any time by the HSD.

These policies may be amended and will be reviewed on a periodic basis to determine if changes are necessary. The Manual will be updated on a regular basis, and HSD reserves the right to change, modify or supersede any of these policies and procedures with or without notice at any time.

As policies are revised throughout the year, they will be incorporated into the Manual. The Manual may be viewed or downloaded from MAD’s home page website at www.hsd.state.nm.us\mad.

A summary list of the policy revisions will also be posted on line each year.

Publishing the Manual should eliminate the need to issue future Letters of Direction to the MCOs. Any future Letters of Direction will only be issued on an as-needed basis.

If there is a conflict between the Manual and the managed care Agreement or NMAC Rules, the Agreement and Rules will control. The Manual is intended to provide guidance. It is not
intended to, nor does it create, any rights that are not contained in the Managed Care Agreement or Rules.

The Manual will be issued and maintained by HSD. It is the responsibility of all members and entities affiliated with Medicaid managed care in New Mexico to review and be familiar with the Manual and any amendments.

If you have any questions about the application of any policy, you should contact the Medical Assistance Division at 505 827-3152.
2 PROVIDER NETWORK

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General Requirement

Anticipated changes in the MCO provider network shall be reported to the MAD Contract Manager in writing within thirty (30) calendar days prior to the change, or as soon as the MCO knows of the anticipated change. Unexpected changes shall be reported within five (5) calendar days.

The MCO is required to submit a Notification, Narrative and Transition Plans A and B to its Contract Manager on anticipated changes to the network. The Manager for either the BH Unit or the LTSS Unit shall be copied on any network change related to either BH or LTSS. Notification is expected whenever a provider informs the MCO of its intent to change or terminate a service(s), which may result in the need for members to transition from one service provider to another, or when a service provider becomes incapable of performing a contracted service. In all instances, the MCO is expected to report how the changes will affect the service delivery system.

In both expected and unexpected changes in the network, the MCO shall assess the significance of the change or closure within ten (10) calendar days of a confirmation by the provider. If the MCO determines the change will not have a significant impact on the system, the Narrative template must be submitted within ten (10) calendar days from the date of notification of change or closure to the Contract Manager. The MCO must explain in the Narrative factors considered in making a determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable). If the MCO determines that the change or closure will significantly impact the delivery system, the MCO is required to submit Transition Plan A (Overall), Transition Plan B (Client Specific) and the Narrative to the Contract Manager within 15 calendar days of official notification to HSD. In the event that HSD determines a network change is significant, the MCO will be required to submit all transition information as requested.

Transition information will be submitted on the templates provided by HSD with all columns completed. The Narrative will be submitted in text format. Updates will be submitted every other week after the initial submission. A final update will be submitted when all consumers are
transitioned. The Notification, Narrative and Transition Plan A will be submitted via email to the Contract Manager. Transition Plan B will be submitted by fax or via a secure website as determined by the MCO and HSD.

Notification:

1) **The Notification must include the following:**
   - Date
   - Name of Provider or Facility
   - Type of Service
   - Region
   - Location (address)/City of the provider or facility closing
   - Total Number of members affected and number of Consumers <=21 and >21
   - Nature of the change
   - Anticipated Date of Closure
   - Transition Plans Required?
   - Narrative Due Date

   If the MCO determines that transition plans will be required, the Notification will also include the following information:

   - Narrative, Transition Plan A and Transition Plan B due dates
   - Name of MCO staff responsible for the Transition and deliverables

2) **Narrative:**
   The Narrative will include the following:

   - How the change affects delivery of, or access to, covered services
   - The MCO’s plan for maintaining access and the quality of consumer care
   - Factors considered in making the determination that the change will not significantly impact the system and provide assurances that all consumers will be transitioned to new providers (if applicable)
   - Transition issues must be identified

3) **Transition Plan A – Overall Transition Template**
   - Preplanning
   - Network Operations
   - Transition Planning
   - Communication with the state
   - Care Coordination
• Other requirements as needed depending on circumstances of closure
• Transition Process Finalized

4) Transition Plan B – Client Specific Template

• Client Name
• Medicaid Number
• Date of Birth
• Parent or Legal Guardian (if applicable)
• Services currently receiving
• Current Provider
• Date of Discharge (if applicable)
• New Provider (or anticipated new provider)
• Date or anticipated date of transition
• First appointment date (for outpatient services)
• Care Coordination and CSA (if applicable)
• Special Conditions/Arrangements/Comments (e.g. barriers to transition)
• CYFD – JJS or PS staff involvement (if applicable)

Core Services Agencies (CSA)

1) The MCOs, in designating additional or new CSAs shall work together to:

• Develop a Request for Application (RFA) in conjunction with the HSD (MAD and BHSD on behalf of the Collaborative). The RFA must include all services to be provided by the CSA, all eligibility requirements, all expectations regarding reporting, intake, discharge, outcomes and required activities to be performed by the CSA as well as any other contractual requirements determined jointly between the MCOs and the state staff.
• Develop one system for processing the applications that ensures that all proposals are received and tracked. Agencies must receive a receipt confirmation and the MCOs will maintain a complete inventory of all proposals received.
• Screen all applications according to defined pre-screening qualifications as required in the RFA in accordance with the time line in the RFA.
• Prepare summary documents detailing the applicants who met the pre-qualifications and those who did not for review by the HSD.
• Hold the mandatory bidder’s conference as described in the RFA and time line.
• Develop a process for receiving questions from applicants and write a draft set of responses to be submitted to HSD staff in accordance with the time line established in the RFA.
• Revise and post the final answers in accordance with the time line in the RFA.
2) **CSA/RFA Review process**

The MCOs will ensure the fairness and integrity of its RFA review process and complete the following steps in the RFA review process:

- Identify a review team that will include state staff;
- Provide training to the review team regarding the RFA process and scoring document.
- Distribute the provider RFA applications to the review team along with score sheets and any written guidance and the questions and responses.
- Coordinate the logistics of the review process.
- Maintain written documentation of the review team recommendations. This will include narratives for each section and an over-all score for each applicant.
- Draft a summary of the recommendations for HSD staff.
- Participate in the presentation of recommendations at a designated Collaborative meeting.
- Send notification letters to all applicants and maintain a tracking system of the notifications.
- Identify in writing performance issues of individual awardees for insertion into the CSA contract.
- Notify the designated HSD staff of any formal complaints or protests from unsuccessful applicants.

3) **Implementation and Oversight of CSA’s**

The MCOs will

- Draft the scope of work language for each CSA and submit to the HSD staff for review and approval.
- Develop a tracking process for contract execution and the return of the signed contracts.
- Assist each agency with the development and execution of an implementation plan.

The MCOs will meet regularly with the HSD staff to:

- Participate in the development of topics for implementation and training and coordinate all logistics for trainings and meetings with HSD staff.
- Identify and address problems and ongoing needs and concerns of the CSAs.
3 MEMBER EDUCATION

Revision Dates: January 1, 2014
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A. 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 distributed shall include a language block that informs 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.

Once a member has requested member material in an alternate format or language, the MCO shall provide all subsequent member materials to the member in such a format unless the member requests otherwise.

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

B. Member Education Prior Approval Process

The CONTRACTOR shall submit to HSD, through its Contract Manager, all written materials that will be distributed to Members (referred to as Member Materials). This includes but is not limited to Member handbooks, provider directories, Member newsletters, Member ID cards and, upon request, any other additional, but not required, materials and information provided to Members designed to promote health and/or educate Members.

All Member Materials must be submitted to HSD in electronic file media, in the format prescribed by HSD. The CONTRACTOR shall submit the reading level and the methodology used to measure it concurrent with all submissions of Member Materials and include a plan that describes the CONTRACTOR’s intent for the use of the Member Materials.

HSD shall review the submitted Member Materials and either approve or deny them within fifteen (15) Calendar Days from the date of submission.
Prior to modifying any approved Member Material(s), the CONTRACTOR shall submit to HSD for prior written approval a detailed description of the proposed modifications in accordance with this Section.

C. **Member Handbook**

The MCO member handbook must include 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 behavioral health 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 behavioral health services and are not required to visit their primary care physician 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;
- Notice to members about the grievance process and about HSD’s fair hearing process;
- Information on the member’s right to terminate enrollment and the process for voluntarily disenrolling 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 behavioral health;
- Information regarding how to obtain a second opinion;
- Information on cost sharing, if any;
• How to obtain information, upon request, determined by HSD as essential during the member’s initial contact with the MCO, which may include a request for information regarding the MCO’s structure, operation, and physician’s or senior staff’s incentive plans;
• Value added benefits which are not covered by the contract 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 Indian health service or a tribal health care facility for services;
• Information on how to report fraud, waste and abuse; and
• Information on member’s privacy rights.

D. The Member Identification (ID) Card

The 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 CONTRACTOR’s name and issuer identifier, with the company logo;
• Phone numbers for information and/or authorizations, including for physical health, Behavioral Health, and Long-Term Care services;
• Descriptions of procedures to be followed for emergency or special services;
• The Member’s identification number;
• The Member’s name (first and last name and middle initial);
• The Member’s date of birth;
• The Member’s enrollment effective date;
• The Member’s PCP;
• Expiration date (the Member’s eligibility review date for the next calendar year);
• The Health Insurance Portability and Accountability Act (HIPAA) adopted identifier, if applicable; and
• Whether the Member is enrolled in the Alternative Benefit Plan.

E. 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., Behavioral Health, physical health and Long-Term Care), 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 shall submit its list of selected members serving on the advisory board annually by February 1st.

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 HSD ten (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 HSD ten (10) Calendar Days in advance of meetings to be held.

In addition to the quarterly meetings, the MCO shall hold at least two (2) additional statewide Member Advisory Board meetings each Contract year that focus on member issues to help ensure that Member issues and concerns are heard and addressed. Attendance rosters and minutes for these two (2) statewide meetings shall be made available to HSD within ten (10) Calendar Days following the meeting date.

The MCO shall ensure that 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.

F. Member Satisfaction Survey

The MCOs shall attend and participate in the survey planning process with the New Mexico Consumer/Family/Caregiver and Youth Satisfaction Project (C/F/YSP) State Steering Committee, made up of HSD staff (MAD and BHSD on behalf of the Collaborative), and take direction from that committee in activities related to the C/F/YSP as follows:

1. Generate and provide to the HSD a random sample of individuals receiving at least one service in the first six months of the each State Fiscal Year as defined in the agreed upon parameters by the C/F/YSP State Steering Committee. The sample will be uploaded to a secure portal.

2. Develop a Scope of Work (SOW) for a consumer-run business to conduct the annual Consumer Satisfaction Survey. The survey shall consist of the Adult, Family/Caregiver and Youth Survey and shall be completed telephonically and face-to-face.

   a. Contract directly with a consumer-run business. The MCOs will retain financial responsibility for this function.
3. Monitor the contract with the consumer-run business to ensure all deliverables are met within timelines established by the C/F/YSP State Steering Committee.

4. Develop a Survey Procedure Manual to document survey procedures and protocols that will be utilized in training Consumer-run agency surveyors conducting telephonic and face-to-face surveys of consumers and family members. A full documentation manual of the training will be developed that can be used for reference or for new hires. An electronic and hard copies will be retained by the consumer run business and HSD. The MCOs will be responsible for the cost of the training and documentation. In subsequent years, if the training material changes, the MCOs would be responsible for modifying the existing manual and providing the new version to the consumer run business and HSD.

5. Provide training to the surveyors of the consumer-run business on phone and face-to-face survey protocol. The MCOs shall provide the training to the surveyor on ONLY survey methodology, including phone and face-to-face etiquette on:
   a. How the surveyor should conduct themselves during the phone interview;
   b. What the rules are (such as surveyor cannot email completed survey to consumer due to the HIPPA laws).

This training shall not include the use of the database tool for data collection. This training includes the methodology for conducting the survey to ensure that: consumer survey participants understand the survey questions, surveyors are professional and considerate in their delivery, confidentiality and privacy statutes and rules are understood and adhered to by surveyors and that inter-rater reliability is established. The MCOs will retain financial responsibility for this function. Inter-rater reliability as used in this document is intended to mean that all surveyors use the same survey methodology and approach (standardized) in order to elicit the same response from a survey participant.

6. Conduct an evaluation of the consumer/family surveyor training and the implementation of the instrument within 10 business days of the training being conducted.

7. Send Letters of Introduction to the facilities where the face-to-face survey is to be conducted.

8. Provide written survey status updates to the C/F/YSP State Steering Committee as requested. The C/F/YSP committee, which shall include a representative of each MCO, creates the timeline every year based on the required tasks for completing the project. Each member provides input regarding due dates of their particular tasks and all parties of the committee agree upon the final timeline. The C/F/YSP committee creates the timeline in the first quarter of each fiscal year.

9. Review survey data results and identify interventions and metrics for system improvement(s) with the C/F/YSP State Steering Committee.

10. Report on performance improvement project(s) related to survey findings to HSD as requested.
11. Based on the results of the survey, the MCOs will perform any additional statistical analysis they feel necessary for quality improvement activities related to the survey results and will retain financial responsibility for this function.

The state C/F/YSP State Steering Committee will develop and maintain the database tool used for collection, storage and reporting of survey data.

1. Provide training to the Consumer-run agency on survey data collection specific to the use of the database tool. Included in this training is a Survey Data Collection Instruction Manual, specific to the use of the database tool. Analyze and compile the results of the survey into an appendix.

12. Write and publish the annual Consumer Satisfaction Project Report.

13. Populate five Uniform Reporting System (URS) tables with the results of the C/FYSP as per SAMHSA.
4  **Care Coordination**

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**A. Overview**

The MCO, through implementation of its policies and procedures, will develop a comprehensive program for continuous monitoring of the effectiveness of its care coordination processes. The policies and procedures will include the staff responsible for the monitoring, how the monitoring will be done as well as the frequency of the oversight. Any issues of concern will be addressed immediately. The strategies will be analyzed for effectiveness and appropriate changes made.

1. The MCO, through its care coordination monitoring, will ensure, at a minimum:
   a. The care coordination tools and protocols are consistently and objectively applied and outcomes are continuously measured (frequency and methodology stated in the policies and procedures e.g. inter-rater reliability) to determine effectiveness and appropriateness of processes;
   b. Staff competencies will be evaluated in these areas, but not limited to:
      i. Level of care assessments and reassessments occur on schedule in compliance with the contract and are submitted to the lead or supervising care coordinator;
      ii. Comprehensive needs assessments and reassessments, as applicable, occur on schedule in compliance with the contract;
      iii. Care plans are developed and updated on schedule in compliance with the contract;
      iv. Care plans reflect needs identified in the comprehensive needs assessment and reassessment process;
      v. Care plans are appropriate and adequate to address the Member’s needs;
      vi. Services are delivered as described in the care plan and authorized by the MCO;
      vii. Services are appropriate to address the Member’s needs (as defined in the policies and procedures);
      viii. Services are delivered in a timely manner;
      ix. Service utilization is appropriate;
      x. Service gaps are identified and addressed in a timely manner (as defined in the policies and procedures);
      xi. Minimum care coordinator contacts are conducted;
      xii. Care coordinator-to-Member ratios are appropriate; and
      xiii. Service limits are monitored (as described in the policies and procedures) and appropriate action is taken if a Member is nearing or exceeds a service limit.
2. The MCO will use an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the 1115 (a) Waiver, federal and State statutes, regulations, the contract and the MCO’s policies and procedures. The functionality will include but not limited to the ability to:

   a. Capture and track key dates and timeframes, including, but not limited to, as applicable, enrollment, date of development of the care plan, date of authorization of the care plan, date of initial service delivery for each service in the care plan, date of each level of care and needs reassessment, date of each update to the care plan, and dates regarding transition from an institutional facility to the community;
   
   b. Capture and track compliance with minimum care coordination contacts as specified in this contract;
   
   c. Notify the care coordinator about key dates, e.g., eligibility end date, date for annual level of care reassessment, date of comprehensive needs reassessment, and date to update the care plan;
   
   d. Capture and track eligibility/enrollment information, level of care assessments and reassessments, and needs assessments and reassessments;
   
   e. Capture and monitor the care plan;
   
   f. Track requested and approved service authorizations, including Covered Services and Value Added Services, as applicable;
   
   g. Document all referrals received by the care coordinator on behalf of the Member for Covered Services and Value Added Services, as applicable, needed in order to ensure the Member’s health, safety and welfare, and as applicable, to delay or prevent the need for more expensive institutional placement, including notes regarding how such referral was handled by the care coordinator;
   
   h. Establish a schedule of services for each Member identifying the time at that each service is needed and the amount, frequency, duration and scope of each service;
   
   i. Track service delivery against authorized services and providers;
   
   j. Track actions taken by the care coordinator to immediately address service gaps;
   
   k. Document case notes relevant to the provision of care coordination; and
   
   l. Allow HSD or its designee to have remote access to case files.

B. Health Risk Assessment

Health Risk Assessment (HRA): The purpose of an initial Health Risk Assessment (HRA) is to identify the Member’s abilities, needs, preferences and supports and to determine the care coordination level. The MCO will conduct an HRA per HSD guidelines and processes, together with the MCO’s policies and procedures, for the purpose of (i) introducing the MCO to the Member, (ii) obtaining basic health and demographic information about the Member, (iii) assisting the MCO in determining the level of care coordination needed by the Member, and (iv) determining the need for a detailed needs assessment.
Members in care coordination Level 1 receive an annual HRA; after an initial HRA, those in Levels 2 and 3 will not have an annual HRA since they will have a comprehensive needs assessment. Those members residing in a nursing facility do not require an HRA; when they are ready to transition back into the community, the MDS and CNA will be used to determine the care coordination level.

The MCO will make reasonable efforts to contact Members to conduct an HRA. Reasonable efforts means documentation of at least three (3) attempts to contact the Member by phone (which will include at least one (1) attempt to contact the Member at the number most recently reported by the Member), followed by a letter sent to the Member’s most recently reported address that provides information about care coordination and how to obtain an HRA.

C. Comprehensive Needs Assessment

A CNA is conducted for Medicaid members eligible for managed care who are identified through the HRA as needing a higher level of care coordination. The HRA identifies significant conditions and risk indicators signifying the potential for Level 2 or Level 3 Care Coordination. The CNA determines the member’s physical health, behavioral health, and long-term care needs, utilizing information from the assessment process to establish a care plan that addresses the needs that have been assessed.

1. During the Transition Period, the MCO shall:

   a. Accept the Member’s nursing facility level of care determination, previously completed by HSD or its designee, until redetermination of the Member’s Medicaid eligibility or scheduled level of care assessment, whichever date is earlier;

   b. Continue providing services previously authorized by HSD or its designee in the Member’s approved Home and Community-Based care plan or Behavioral Health Treatment or service plan, without regard to whether such services are being provided by Contract or Non-Contract providers and shall not reduce these services until the MCO conducts a comprehensive needs assessment and develops a care plan in accordance with the Contract, Section 4.4.9;

   c. Complete the comprehensive needs assessment within ninety (90) calendar days of the Health Risk Assessment (HRA), reminding members at least two weeks prior to the date scheduled for the assessment, through the most effective means of communication, about their scheduled date;

   d. Should the MCO become aware of any significant change in a Member’s medical condition, signifying increased needs, prior to the scheduled time for the comprehensive needs assessment, conducting the assessment must be expedited and an update of the Member’s care plan executed, initiating any needed changes in services within ten (10) calendar days of becoming aware of the change in the Member’s condition and needs.
Comprehensive needs assessments must be performed by the MCO, through the utilization of an assessment tool that has been previously approved by HSD, assessing the Member’s medical/physical health, behavioral health, long term care and social needs. The assessment tool may include the identification of targeted needs related to improving health, functional outcomes, or quality of life outcomes (e.g., related to targeted health education, pharmacy management, or increasing and/or maintaining functional abilities, including provision of covered services). Any changes to the assessment tool must be approved by HSD thirty (30) calendar days prior to use by the MCO. The comprehensive needs assessment must be conducted by a staff professional care coordinator, employed by the MCO. While additional partnership with community health workers, community health representatives, community behavioral health representatives and other advocates; is encouraged, the comprehensive needs assessment is the sole responsibility of the MCO care coordinator.

The CNA must be conducted in the member’s primary place of residence. In scheduling the comprehensive needs assessment, the MCO is advised to involve collateral respondents for the assessment interview, including family members, caregivers, community health representative/worker, and/or other significant social support individuals, with the consent of the Member. Additional arrangements must also be discussed with the Member when scheduling the assessment to evaluate, in advance, any need for language translation, including signing or communications board use, for the comprehensive needs assessment interview process.

CNAs are performed face-to-face with the Member and collateral parties in the home, unless an exception has been granted by HSD. Home setting is defined as the primary residence for the Member in the community, which can include personal single home dwelling, family member’s residence where Member may be living, assisted living facility, temporary shelter, and so forth, where there is an identifiable address. If the Member is homeless, the comprehensive needs assessment may be conducted at a location, mutually agreeable to the Member, such as a church meal site program, community non-profit organization center, community mental health agency, food bank site, etc. Exceptions to requirement for assessments being completed in the home must be made directly to the MCO contract manager at HSD and will be reviewed on an individual case by case basis.

All efforts must be made to negotiate with the Member about the importance of participating with a CNA. The MCO must provide documentation of further negotiations with the Member and/or legal representatives when refusal by the Member is articulated. CNAs are considered to be best practice and valid when conducted in the home setting. The home setting must be evaluated for health, welfare and safety of the Member. The CNA, when conducted with the Member in his/her home, determines any structural problems for Member’s mobility, access, need for safety enhancements, such as smoke detectors, fire extinguishers, ramps, guard rails, bathroom equipment, fall prevention concerns-throw rugs, doorway access for wheel chairs, plumbing and electricity issues, nutritional concerns, (such as, no food resources or food/beverage items identified as being beyond expiration dates), and other structural damages.
such as mold, broken windows, entry doors without locks, broken flooring. Additional considerations assess rodent/pest infestation, fire hazards due to electrical wiring issues and clutter/hoarding, as well as outdoor hazards due to overgrown weeds and undergrowth of yards/trees.

The CNA further observes the existence of other parties dwelling in the home possibly presenting support or risk to the Member. When a Member refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the needs assessment with the Member, emphasizing that this assessment makes the determination of useful resources to meet the Member’s needs, such as the community benefit for personal care assistance, special home environment modifications and adaptive equipment. In documented refusal circumstances, the MCO will submit a proposal for a basic care plan with minimum services outlined and suspending any requests for increased services/personal care hours until an assessment is conducted and completed.

2. At a minimum, the CNA shall:

   a. Assess physical and behavioral health needs, including but not limited to, current diagnoses; history of significant physical and behavioral health events, including hospitalizations and emergency room visits; medications; allergies; providers involved in Member’s care; Durable Medical Equipment (DME); brief substance abuse screen (CAGE) and history; family medical and behavioral health, (mental health and substance use/abuse), history; cognitive capacities, (including evaluation of alertness, orientation, history of head/brain injury); health-related lifestyle (smoking, food intake/nutrition, sleep patterns, exercise, continence); and functional abilities, including Activities of Daily Living/ADLs (mobility, grooming, bathing, eating, medications concerns (i.e. self-administration and safety) and Instrumental Activities of Daily Living/IADLs (i.e. money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, grocery shopping);

   b. Assess additional long-term care needs including, but not limited to, environmental safety including items such as smoke detectors, pests/infestation, emergency awareness and plans, trip and fall dangers, mobilization access issues such as doorway widening, ramps and other environmental improvement needs;

   c. Include a risk assessment, using a tool and protocol approved by HSD and develop, as applicable, a risk agreement that shall be signed by the Member or his/her representative and that shall include identified risks to the Member, the consequences of such risks, strategies to mitigate the identified risks, and the Member’s decision regarding his/her acceptance of risk;

   d. Assess disease management needs, including identification of disease state, need for targeted intervention and education, and development of appropriate intervention strategies;
e. Determine a social profile including, but not limited to, living arrangements; natural and social support systems which are available to assist the Member; demographics; transportation; employment; financial resources and challenges (other insurance, food, utilities, housing expenses); Medicare services; other community services being accessed, such as senior companion services, meals-on-wheels, etc.; living environment (related to health and safety); IADLs; Individualized Education Plan (IEP); and Individual Service Plan (ISP) for Developmental Disabilities or Medically Fragile Waiver Program recipients, (if applicable);

f. Identify possible suicidal and/or homicidal thinking, planning/intent and lethality risk, history of aggressive and/or violent behaviors, history of running away and wandering for both adults and children;

g. Identify cultural information, including language and translation needs and utilization of ceremonial or natural healing techniques; and

h. Ask the Member for a self-assessment regarding their viewpoint of their condition(s) and service needs.

3. Reassessments

The CNA shall be conducted at least annually for Level 2 Care Coordination and semi-annually for Level 3 Care Coordination, to determine if the care plan is appropriate for the Member and if a higher or lower level of care coordination may be needed. Additional comprehensive needs assessments may also be conducted, as the care coordinator deems necessary, due to requests from the Member, provider, family member or legal representative or as a result of a change in health status and/or social support situation.

Specific indicators warranting a new CNA to be performed include, significant changes in Member’s medical and/or behavioral health condition; changes in setting of care, such as hospitalization, rehabilitation and/or short-term nursing home admission (long-term nursing home stay(s) require administration of the MDS), residential treatment facility admission; changes in the Member’s family or natural/social support system (such as, sudden illness and/or convalescence or death of a family caregiver); living arrangement disruption (loss of residence, eviction, fire/flooding, move to another family home); involvement of Adult Protective Services (APS), Child Protective Services and/or other NM Children, Youth & Family (CYFD) interventions; changes in the amount of caregiver services requested and requested amount exceeds the range of hours corresponding with Member’s existing assessment score.

D. Staffing Requirements and Delegation

The MCO may utilize a care coordination team approach to performing care coordination activities, with the MCO’s care coordination team consisting of the Member’s primary care coordinator and specific other individuals with relevant expertise and experience appropriate to address the needs of Members. While the MCO may subcontract the Health Risk Assessment
(HRA) activities, the CNAs must be performed by professional staff care coordinators employed by the MCO. The MCO may use local resources, such as Indian Health Service, Tribes and Tribal Organizations and Urban Indian Organizations (I/T/Us); Patient-Centered Medical Homes (PCMH) and Health Homes; Core Service Agencies (CSAs) for Behavioral Health; Tribal services; and other local service organizations, to collaborate in care coordination functions. The role of community health workers (community health advisors, community health representatives, lay health advocates, promotoras, outreach educators, peer health promoters and peer health educators), is to supplement and support the care coordination function required in managed care. The performance of the CNA is the primary responsibility of the MCO.\(^1\)

The MCO will implement policies and procedures that will define and specify the qualifications, experience and training of each member of the care coordination team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator.

Maximum caseload per care coordinator, by designated care coordination level as established by HSD, shall not be exceeded by the MCO. To the extent that I/T/Us, PCMHs, Health Homes, CSAs and Community Health Workers are utilized to perform care coordination functions, these local entities may be utilized in the caseload ratios. Caseload to care coordinator ratios are stipulated in the managed care contract.

Costs associated with community health workers can include salaried employees, independent community health workers and/or contracted groups of community health workers, shall be considered as part of the care coordination expense (characterized as an administrative cost for the MCO).

Costs associated with Care Coordination functions, including community health workers will be categorized as care coordination expenditures. Care coordination expenditures are deemed medical expenditures for use in the medical loss ratio calculation. Encounter data is not required to be reported for community health workers and no codes will be developed.

MCOs shall submit, for HSD review and approval, an annual Care Coordination Staffing Plan, which at a minimum shall specify:

1. The number of care coordinators, care coordination supervisors, other care coordination team members that the MCO plans to employ;
2. The ratio of care coordinators to Members;
3. The MCO’s plans to maintain ratios as outlined by care coordination level and the explanation of the methodology used for determining such rations;

4. How the MCO will ensure that such ratios are sufficient to fulfill the contract agreement requirements;
5. The roles and responsibilities for each member of the care coordination team;
6. A strategy that encourages the use of Native American care coordinators and limits duplication of services between I/T/U and non-I/T/U providers;
7. How ratios are adjusted to accommodate travel requirements for those care coordinators serving Members in Rural/Frontier areas of the State and/or for those Members that require extraordinary efforts from the assigned care coordinator; and
8. How the MCO will use care coordinators to meet the needs of New Mexico’s unique population.

The MCO shall ensure that Members have a telephone number for direct contact with their care coordinator and/or a member of their care coordination team, (without being routed around through several contact points), during normal business hours (8 a.m. - 5 p.m. Mountain Standard Time). When the Member’s care coordinator or a member of the Member’s care coordination team is not available, the call shall be answered/facilitated by another qualified staff person in the MCO’s care coordination unit. Calls requiring immediate attention shall be “warm” transferred directly to another care coordinator, not letting call go to voice mail. After normal business hours, calls requiring immediate attention by care coordinator shall be handled by the Member services line, as stipulated by Section 4.15.1 of the contract.

When Native American Members request assignment to a Native American care coordinator and the MCO is unable to provide a Native American care coordinator to such Members when requested, the MCO must ensure that a Community Health Worker/Community Health Representative is present for all in-person meetings between the assigned care coordinator and the Member.

The MCO must accommodate Member’s requests to change to a different care coordinator if desired and there is an alternative care coordinator available. Such availability may take into consideration the MCO’s need to efficiently deliver care coordination in accordance with the requirements in the contract. In ensuring quality and continuity of care, however, the MCO shall make efforts to minimize the number of changes in a Member’s care coordinator. Section 4.4.12.13 of the contract, outlines circumstances that the MCO may need to initiate change in a Member’s assigned care coordinator:

- Assigned care coordinator is no longer employed by the MCO;
- There is a conflict of interest preventing neutral support for the Member;
- Care Coordinator is on temporary leave from employment; or
- Caseload of the assigned care coordinator must be adjusted due to its size or intensity.
The MCO shall develop policies and procedures regarding notice to Members of care coordinator changes initiated by either the MCO or Member, including notice of planned care coordinator changes initiated by the MCO.

The MCO shall ensure continuity of care when care coordinator changes are made. The MCO shall demonstrate use of best practices by encouraging newly assigned care coordinators to attend a face-to-face transition visit with the Member and the out-going care coordinator, when possible.

Initial training shall be provided by the MCO to newly hired care coordinators and ongoing training provided at least annually to all care coordinators. Involvement of New Mexico Tribes as training instructors should be utilized where appropriate..

E. Comprehensive Care Plan Requirements

Description: This policy is in conjunction with all elements described in Care Plan Requirements outlined in the managed care contract, which defines the processes for development, implementation and management of a care plan for all members in Levels 2 and 3 of care coordination. Members in Level 1 care coordination will not need to have a care plan. The MCO is responsible for ensuring a care plan is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the care plan.

1) Comprehensive Care Plan Scope and Process

The MCO must establish a process to ensure coordination of care for members that includes:

   a. Coordination of the members health care needs through the development of the care plan;
   b. Collaboration with the member, member’s friends, family, members PCP, specialists, Behavioral Health providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan;
   c. With the members consent to share information, the care plan should be shared and utilized by those involved in providing care to the member. (e.g. BH providers should be aware and take into consideration the members physical health care issues when working with the member); and
   d. Verification of all decisions made regarding the member’s needs and services, and ensures all information is documented in a written, comprehensive care plan.

2) Comprehensive Care Plan Development and Management

   a. The Care Plan serves as a working and guiding tool of reference for integrating the member’s treatment plan(s) into a language that the member and or/family member can understand.
b. The Care Coordinator shall:
   
i. Ensure the member or member’s legal representative understands, reviews, signs and dates the care plan.
   
i. Provide a copy of the members completed care plan to the member, members legal representative as applicable or other providers authorized to deliver care to the member in a format that is easily readable (e.g. 12 font).
   
ii. Confirm that family, providers, or any other relevant parties are included in the treatment and planning of the members care plan.
   
iii. Ensure timelines for the development and implementation and/or update the care plan as needed.
   
iv. Facilitate treatment and coordinate with providers to assist the member and his or her family with navigating the system scheduling appointments, arranging transportation, or advocating for the member as needed.
   
v. Verify that services have been initiated and/or continue to be provided as identified in the care plan and ensure services continue to meet the member’s needs.
   
vi. Maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the members care.
   
vii. Identify, address and evaluate service gaps to determine their cause and minimize any gaps going forward and ensuring back-up plans are implemented and effectively working.
   
viii. Identify changes to member’s risk, address those changes and update the member’s risk agreement as necessary.
   
ix. Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.
   
x. Educate members with identified disease management needs by providing specific disease management interventions and strategies.
   
xi. Educate the member about his or her ability to have an Advance Directive and ensure the member’s decision is well documented in the member’s file.
   
xii. Educate members about Medicaid services available as appropriate (e.g. Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant Mental Health).

3) The Comprehensive Care Plan Required Elements include the following:
   
a. Pertinent member demographics and enrollment data.
   
b. Ensure implementation of interventions and the dates by which the interventions must occur and identify specific agencies or organizations with which treatment must be coordinated, including non-Medicaid providers.
c. Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.
d. Members’ current status, including present levels of function in physical, cognitive, social, and educational domains.
e. Member or family barriers to receiving treatment, such as a member or family member’s ability to travel to an appointment.
f. Identify the member or family’s strengths, resources, priorities and concerns related to achieving mutual recommendations made in caring for the member receiving services.
g. Services recommended achieving the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member’s desired outcomes.
h. Identified services provided by natural supports that are scheduled to be enhancers and back-up (including emergency purposes) to services that are authorized by the MCO.
i. An interdisciplinary team including but not limited to: the care coordinator, social worker, registered nurse, medical director, and PCP must be identified to develop, implement and update the care plan as needed.

4) Comprehensive Care Plan Revisions

The care plan will be revised when the member experiences one of the following circumstances:

a. Risk of significant harm. In this case the care coordination team will convene within one calendar day, in person or by teleconference; if necessary the care plan will be modified accordingly within 72 hours;

b. Major medical change;

c. The loss of a primary caregiver or other significant person;

d. A serious accident, illness, injury or hospitalization that disrupts the implementation of the care plan;

e. Serious or sudden change in behavior;

f. Change in living situation;

h. Proposed change in services or providers (e.g. Community Benefit);

i. It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect or exploitation;

j. Any team member requests a meeting to propose changes to the care plan;

k. Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole)

l. Requested by HSD.
F. Ongoing Care Coordination

Description: This policy along with all elements described in Ongoing Care Coordination outlined in the managed care contract, defines how the MCO shall perform real time and ongoing care coordination to ensure all members receive the appropriate care.

Ongoing care coordination functions shall include all elements defined in the contract including the following:

1. Proactively identify gaps and address the needs of the member, including develop and/or update the care plan as needed.
2. Ensure when a member’s level of care coordination increases or decreases that continuity of care is always maintained.
3. Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.
4. Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member’s goals and foster independence.
5. Coordinate and provide access to specialists, as needed; relevant long term specialty providers, relevant emergency resources, relevant rehabilitation therapy services, relevant non-Medicaid services, etc.
6. Education regarding service delivery through Medicare and/or Medicaid.
7. Measure and evaluate outcomes designated in care plan and monitor progress to ensure covered services are being received and assist in resolution of identified problems.
8. Proactively work to continue to achieve coordination of physical, behavioral health and long term care services.
9. Maintain consistent communication and contact with member’s PCP, specialists, and other individuals involved in the member’s care.
10. Maintain and monitor the member’s Community Benefit and provide assistance with complex services.
11. Consistently consider member and provider input to identify opportunities for improvement.

G. Engagement of Members

1) Background

HSD recognizes there may be a select few managed care members who present challenges to the service delivery system due to the complexity of their needs. This policy is designed for members who demonstrate inappropriate behaviors and/or frequent contact of State and MCO staff, and/or have been unresponsive to traditional care coordination efforts and compliant with recommended behavioral health services.
This group of “high health risk/high resource utilization” (HHR/HRU) is different than other populations and individuals in the care system because denying or delaying care to them has significant immediate negative consequences to their health and safety. The risk to the individual can be documented in assessments, contact notes and care plans. Responding to the challenges presented by this category of members requires monitoring of attempted delivery of care, documenting interactions and thresholds of behavior or conditions that escalate events to a higher level of response and identifying appropriate teams to design and implement responses. Consistent, well-crafted responses to concerns are essential when providing care or addressing resistance to care. This will minimize excessive use of State, MCO and provider resources as well as minimizing risk to the individual’s health and safety.

2) Recommendation

HSD in collaboration with the State Medicaid Physician has developed the following policy/procedure to ensure consistent responses to challenges presented by the HHR/HRU population. This protocol is to be utilized across MCOs, agency providers and State employees and programs for each recipient identified as part of this population. The expected result is a more efficient use of resources to achieve an optimal outcome for the individual. This is intended to free time and energy to manage all complex individuals in the care system and to achieve optimal levels of health and safety for all individuals.

3) Intervention Procedures/Policies

Care delivery literature recommends the use of behavioral contractual agreements with members so that all parties agree on appropriate responses in a non-compliant care situation. The State may partner with MCOs to make this intervention consistent for all MCOs and all individuals identified as HHR/HRU.

At the threshold of risk agreed upon by the MCO, a meeting is arranged with the individual and appropriate recipients of the care team. This team must include the care coordinator, a management level staff of the MCO and a high level medical staff of the MCO. The member may request one or two people to be in attendance.

The intention of the meeting with the participant is to:

- Establish/discuss optimal outcome for health and safety.
- Identify the issues interfering with optimal health and safety outcomes.
- Clarify roles for each member of the team.
- Clarify rules of engagement (who can call who when, etc.) and program regulations.
- Assign tasks to each team member with timeline.
• Sign agreement that documents the discussion and assignment of tasks and holds each member accountable.
• Schedule 2nd meeting within two weeks.
• Second meeting is a final meeting. Review tasks. Discuss/establish consequences of any failure to deliver on tasks. Sign contract/care plan. (Includes updates weekly and addressing ongoing/emergent issues at a bi-monthly meeting.)
• Schedule updates between participants, MCO staff on a regular basis.
• Maintenance of documentation is with MCO, participant and natural supports.

When recipients of this population are identified, the MCOs will designate one point of contact and communicate that point of contact to HSD/MAD and other involved individuals. If the identified recipient calls HSD/MAD or other agencies, the individual will be referred back to the MCO point of contact.

If the process outlined above does not provide resolution, then the MCOs will utilize their complex case team and complex case rounds protocol.
5  **TRANSITIONS OF CARE**

Revision Dates: January 1, 2014

Review Date: January 1, 2014

Initial

Effective Date: January 1, 2014

In managed care, HSD will continue its commitment to providing the necessary supports to assist members to reintegrate into the community from institutional facilities. The State's activities will include:

- Providing the necessary education and information on the front end for recipients in institutional facilities to understand the available opportunity;
- Identifying eligible recipients;
- Providing the necessary supports to facilitate transition;
- Monitoring the success of the transition process.

The MCOs shall develop and implement methods for identifying Members who may have the ability and/or desire to transition from an institutional facility to the community. Such methods shall include, at a minimum:

- The comprehensive needs assessment
- PASRR
- MDS
- Identification of wrap-around services
- Provider referral
- Ombudsman referral
- Family member referral
- Change in medical status; and/or
- Member self-referral

MCOs must identify and facilitate coordination of care for all members during changes or transitions between MCOs, as well as changes in service areas, sub-contractors, and/or health care providers.

**A. Members With Special Circumstances:** The following members may require additional or distinctive assistance during a period of transition. This includes members with:
1) Medical conditions or circumstances such as:

a. Pregnancy (especially women who are high risk and in third trimester, or are within 30 calendar days of their anticipated delivery date)
b. Major organ or tissue transplantation services which are in process
c. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing facilities, or other facilities,
d. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments; and/or
e. Significant behavioral health conditions (e.g., SMI, SED, SUD and COD) that require ongoing specialist care and appointments.

2) Members who are in treatment such as:

a. Chemotherapy and/or radiation therapy, or
b. Dialysis.

3) Members with ongoing needs such as:

a. Durable medical equipment including ventilators and other respiratory assistance equipment;
b. Home health services and/or Community Benefit services;
c. Medically necessary transportation on a scheduled basis;
d. Prescription medications, and/or
e. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.

4) Members who at the time of their transition have received prior authorization or approval for:

a. Scheduled elective surgery or surgeries;
b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;
c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period;
d. Appointments with a specialist located out of the MCO service area, and
e. Nursing facility admission.

For those Members whose transition assessment indicates that they are candidates for transition to the community, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision.
to pursue transition or until the transition has occurred and a new care plan is in place. The transition plan shall address the Member’s transition needs including but not limited to:

- Physical and behavioral health needs
- Selection of providers in the community
- Housing needs
- Financial needs
- Interpersonal skills; and safety

The MCOs shall conduct an additional assessment within 75 calendar days after transition to determine if the transition was successful and identify any remaining needs.

B. Transitions of Care from Higher Levels of Care to a Lower Level of Care

The MCO shall develop and implement policies and procedures for ensuring that members transition successfully from higher levels of care (e.g. acute inpatient, residential treatment centers, social detoxification programs, treatment foster care, etc.) to the most appropriate lower level of care. Transitions from inpatient and behavioral health residential treatment facilities for both children and adults must be addressed. At a minimum, the following must be addressed:

- Maintain on-going communication, enlist the involvement of and coordinate with state-run facilities to monitor and support their participation in the member’s care.
- Care coordinators must be knowledgeable of non-Medicaid behavioral and physical health programs/services, statewide, available to its members in order to facilitate referrals, coordinate care, and ensure transition to community based services.
- Ensure that members receive follow-up care within 7 calendar days of discharge from a higher level of care to a lower level of care but receive follow up care no longer than 30 calendar days following other discharges.

C. Notifications Required of MCOs

Relinquishing MCOs must provide relevant information regarding members who transition to a receiving MCO.

Relinquishing MCOs who fail to notify the receiving MCO of transitioning members with special circumstances, or fail to send the transition notification, will be responsible for covering the member's care resulting from the lack of notification, for up to 30 calendar days.

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2 Please see the CMS Standard Terms and Conditions for New Mexico’s 1115 Waiver.
MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, sub-contractors or other providers, as appropriate during times of transition.

Receiving MCOs must provide new members with their handbook and emergency numbers within ten calendar days of transition for acute care members and 12 calendar days of transition for members (allows for care coordination on-site visit).

If a member is referred to and approved for enrollment, the relinquishing MCO must coordinate the transition with the receiving MCO to assure that applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.

**D. Transitions From a Nursing Facility to the Community**

If a member is determined to no longer need long term care in a nursing facility, and the member is determined eligible for Community Benefits, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of 60 calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The member's care coordinator must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained.

**E. Transitions of Members Turning 21 Years of Age**

All members, including those who are under the care of Early Periodic Screening and Diagnostic Treatment (EPSDT), must be transitioned to other services on their 21st birthday. The care coordinator must initiate a transition plan by the age of twenty (20) years which is ongoing until the member leaves the EPSDT program.

The transition plan must:

1. Establish a plan that is age appropriate and addresses the current transition needs of the member (i.e., health condition management, developmental and functional independence, education, social and emotional health, guardianship, transportation);
2. Ensure families, members, and their primary care providers are part of the development and implementation of the transition plan;
3. Document the transition plan in the medical record;
4. Provide family and member with a copy of the transition plan;
5. Establish a timeline for completing all services the member should receive through EPSDT prior to his or her twenty-first birthday;
6. Review and update the plan and timeline with member and family prior to official transition to adult provider;
7. Advise the member’s primary care provider of the discharge and ensure coordination of the services with the adult primary care provider.

F. **Members Hospitalized During an Enrollment Change**

The MCO will make provisions for the smooth transition of care for members who are hospitalized on the day of an enrollment change. The provisions must include policies for the following:

1. Authorization of treatment by the receiving MCO on an individualized basis. The receiving MCO must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
2. Notification to the hospital and attending physician of the transition by the relinquishing MCO. The relinquishing MCO must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving MCO for authorization of continued services. If the relinquishing MCO fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing MCO will be responsible for coverage of services rendered to the hospitalized member for up to 30 calendar days. This includes, but is not limited to, elective surgeries for which the relinquishing MCO issued prior authorization.
3. Coordination with providers regarding activities relevant to concurrent review and discharge planning must be addressed by the receiving MCO, along with the mechanism for notification regarding pending discharge.
4. Transfer of care to a physician and/or hospital affiliated with the receiving MCO. Transfers from an out-of-network provider to one of the receiving MCO providers cannot be made if harmful to the member's health and must be determined medically appropriate. The transfer may not be initiated without approval from the relinquishing MCO primary care provider, or the receiving MCO Medical Director.

**NOTE:** Members in Critical Care Units, Intensive Care Units and Neonatal Intensive Care Units require close consultation between the attending physician and the receiving MCO physician. If a member is admitted to an inpatient facility while still assigned to the relinquishing MCO, and discharged after transition to the receiving MCO, both must work together to coordinate discharge activities.

The relinquishing MCO will be responsible for coordination with the receiving MCO regarding each specific prior authorized service. For members known to be transitioning, the relinquishing MCO will not authorize hospital services such as elective surgeries scheduled less than 15 calendar days prior to enrollment with the receiving MCO. If authorized to be provided during this time frame, the service for the transitioning member will be the financial responsibility of the MCO who authorized the service.
G. Transition During Major Organ and Tissue Transplantation Services

If there is a change in MCO enrollment, both the relinquishing and receiving MCOs will be responsible for coordination of care and coverage for members awaiting major organ or tissue transplantation from the time of transplantation evaluation and determination through follow-up care after the transplantation surgery. If a member changes MCO enrollment while undergoing transplantation at a contracted transplant center, the relinquishing MCO is responsible for contracted components or modules of the service up to and including completion of the service modules that the member is receiving at the time of the change. The receiving MCO is responsible for the remainder of the module components of the transplantation service.

If a member changes to a different MCO while undergoing transplantation at a transplant center that is not a contracted provider, each MCO is responsible for its respective dates of service. If the relinquishing MCO has negotiated a special rate, it is the responsibility of the receiving MCO to coordinate the continuation of the special rate with the respective transplant center.

H. Enrollment Changes For Members Receiving Outpatient Treatment For Significant Medical Conditions

MCOs must have protocols for ongoing care of active and/or chronic "high risk" (e.g., outpatient chemotherapy, home dialysis, etc.) members and pregnant members during the transition period. The receiving MCO must have protocols to address the timely transition of the member from the relinquishing primary care provider (PCP) to the receiving PCP, in order to maintain continuity of care.

The receiving MCO must address methods to continue the member's care, such as contracting on a negotiated rate basis with the member's current provider(s) and/or assisting members and providing instructions regarding their transfer to providers affiliated with the receiving MCO.

Receiving MCOs are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new MCO within the last trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.
6 Nursing Facility Level of Care Determinations

Revision Dates: January 1, 2014

Review Date: January 1, 2014

Initial
Effective Date: January 1, 2014

A. Purpose

This policy establishes guidelines and restrictions for all MCOs regarding nursing facility services.

B. Definitions

See 8.312.2UR

C. Nursing Facility (NF) Medical Eligibility Criteria

See 8.312.2UR

D. Nursing Facility’s Procedures for Requests for Prior Approval

1. All requests for prior approval shall contain appropriate documentation and must be completed for each resident for every situation requiring prior approval. (See the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria for documentation requirements.) All requests for prior authorization are submitted to the resident’s MCO by fax.

2. Physician’s, Nurse Practitioner’s, Clinical Nurse Specialist’s or Physician Assistant’s Orders
   a. A valid order must:
      i. Be signed by a Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant;
      ii. Be dated and,
      iii. Indicate the LOC – either high NF (HNF) or low NF (LNF).
   b. Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the Physician, Nurse Practitioner or Physician Assistant.
   c. Verbal or telephone orders are permitted. The order must be taken by a RN or LPN who must also sign and date the order. It must be clearly indicated that the order is a telephone or verbal order with the name of the Physician, Nurse Practitioner or
Physician Assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order.

3. The MCO approves the documentation and makes a LOC determination following the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria within five (5) business days of receiving a completed packet.

4. When required documentation is missing, a “Request for Information” (RFI) sheet will be generated by the MCO and sent to the provider. If the required documentation is not provided to the MCO within fourteen (14) business days the request will be technically denied. The MCO will make three (3) attempts during the fourteen (14) business day period to contact the NF to obtain information.

**NOTE:** A formal Request for Information (RFI) to the provider to justify the HNF request is not required when reviewing and processing HNF requests that clearly do not meet HNF criteria but do meet Low NF (LNF) criteria (no new order required); however, the MCO will continue to use the RFI process for requests reflecting that the individual may be eligible for HNF LOC.

5. The MCO faxes the notification form with authorization and date span to the NF.

**E. Denial of Requests for Prior Approval:**

If the LOC criteria are not met and the request for placement is denied, the MCO will send the referring party and the member a denial letter within 5 business days of a completed packet, with the reason for denial as determined by the physician. The requesting parties then have an opportunity to request reconsideration or appeal. After the parties have exhausted the MCO appeal process, the member may request an administrative hearing of the MCO decision.

**F. Reserve Bed Days:**

Medicaid pays to hold or reserve a bed for a resident in a Nursing Facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below.

1. Medicaid covers six reserve bed days per calendar year for every long term care resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval.
2. Medicaid covers an additional six reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan.
   a. A resident’s discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.
   b. The prior approval request must include the resident’s name, Medicaid number, requested approval dates, copy of the discharge plan, name and address for
individuals who will care for the resident during the visit or placement and a written physician order for trial placement.

3. Nursing facilities use the following procedures for prior approval for additional discharge reserve bed days. The NF must submit the request for prior approval for additional discharge reserve bed days to the MCO in which the resident is enrolled. The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days.

G. Initial Determination, Redetermination, and Pending Medicaid Eligibility:

1. Initial Determination: See 8.312.2UR.
2. Redetermination: See 8.312.2UR. The medical documentation must be faxed and received by the MCO a minimum of sixty (60) calendar days prior to the start date of the new certification period for LNF and thirty (30) calendar days prior for HNF.
3. Length of Stay Periods: See 8.312.2UR.
4. Pending Medicaid Eligibility: Prior approval reviews can be done when the service is furnished before the determination of the effective date of the resident’s financial eligibility for Medicaid. If the resident is applying for Medicaid, both financial and medical eligibility at the same time, please write “MEDICAID PENDING” in the type of request box on the Notification form. Please Note: A resident on Supplemental Security Income (SSI) is not Medicaid Pending.
   a. When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed packet of required documentation. The Prior Authorization form should have “MEDICAID PENDING” in the type of request box on the Notification form.
   b. The MCO will review the information submitted and determine the LOC.
5. The Prior Authorization form will be completed by the MCO and sent to the NF.

H. Retroactive Medicaid Eligibility:

Written requests for prior approval based on a resident’s retroactive financial eligibility must be reviewed by the MCO within thirty (30) calendar days of the date of the eligibility determination. The NF must submit medical documentation to the MCO.

I. Re-admission Reviews:

A re-admission review is required when the resident has left the NF and then returns, after three (3) midnights in a hospital, to a different LOC.
1. The NF has to submit a re-admit MCO approval request form within thirty (30) calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident’s admission note back to the NF.
   a. When the resident is re-admitted to the NF and has more than thirty (30) calendar days left on his/her certification, days will be assigned from the re-admit date. The NF sends the notification form to the MCO along with supporting documentation.
   b. If the resident has less than thirty (30) calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit redetermination (annual or continued stay) request on the notification form along with supporting documentation.

J. Retrospective Reviews:

Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the NF. Medicaid pending reviews are never considered late.

A request for retrospective review for initial, redetermination or re-admit reviews is considered in the following situations only:

1. Unexcused late reviews:
   a. For the first six (6) months of Centennial Care (ending June 30th, 2014), the MCOs shall not impose unexcused late penalties to NFs.
   b. Starting July 1st, 2014, the NF may lose payment for each day that the NF LOC review is submitted late.
2. Excused Late Reviews: Prior authorization forms not submitted timely due to reasons beyond the control of the NF must be submitted with a detailed written explanation and documentation that supports the request for excusable late review.
3. Reimbursement and retrospective reviews:
   a. If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO.
   b. Medicaid will not reimburse NFs for dates of service (DOS) not covered by the MCO prior authorization form. In addition, the Medicaid member cannot be billed for the service.

K. Transfer from Another NF:

If a resident is admitted to one NF from another NF, the following procedures apply:

1. The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO.
a. If there are more than thirty (30) calendar days on the resident’s current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span.
b. If there are less than thirty (30) calendar days remaining on the resident’s current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write “TRANSFER” in the type of request box on the notification form.

2. The NF receiving the resident receives the status of resident’s reserve bed days from the MCO through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident’s NF records.

L. Change in Level of Care (LOC):

All changes in LOC require a new notification form that should be submitted within thirty (30) calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write “LEVEL OF CARE CHANGE” in the type of request box on the notification form. The NF must provide a signed and dated order from the Physician, Nurse Practitioner or Physician Assistant as well as any documentation to support the LOC request (see New Mexico Nursing Facility Level of Care Instructions and Criteria). The date the LOC change occurred must be clearly stated.

M. Discharge Status:

Discharge status occurs when a resident no longer meets the level of care that qualifies for nursing home placement, but there is no option for community placement of the resident at that time. Individuals are often already residing in a nursing facility at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in a nursing facility may clinically improve to the point that they no longer meet nursing facility LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the nursing facility. Community based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the nursing facility. Physically discharging the resident under such circumstances may put the resident’s health at risk.

To accommodate this health care issue the New Mexico Medicaid program allows for temporary continuation of coverage at Low NF level of reimbursement while the NF and the MCO address the development of community placement resources on an ongoing basis to meet the resident’s lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident is termed “Discharge Status;” however, Discharge Status
does not mean that the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility.

1. **Initial Discharge Status** is authorized at Low NF for a maximum of ninety (90) calendar days, based upon the MCO physician determination.

2. **Continued Stay Discharge Status** is authorized at Low NF for not less than one hundred eighty (180) calendar days and up to three hundred sixty-five (365) calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident’s Discharge Status and document the facility staff’s and MCO care coordinator’s ongoing attempts to find and develop appropriate community placement options for the resident. The facility should document why the resident must remain in a nursing home environment if the resident is at risk for failure to thrive upon discharge to a community placement. Failure to submit sufficient documentation specifying the facility’s discharge planning efforts could result in the denial of prior authorization. The resident’s inability to afford assisted living services may be a consideration in discharge planning.

N. **Reconsideration, Appeal, Administrative Hearing.**

1) Reconsideration:

Providers who disagree with a NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on his or her behalf. Requests for reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the re-review decision notice. The MCO performs the reconsideration and notifies the NF and Member in writing of a decision within eleven (11) business days of receipt of the reconsideration request. The written notice also includes information on a Member’s right to request an HSD administrative hearing after the Member has exhausted his or her MCO’s appeal process.

2) The request for reconsideration must include the following:

   a. Statement that reconsideration is requested.
   b. Reference to the challenged decision or action;
   c. Basis for the challenge;
   d. Copies of any document(s) pertinent to the challenged decision or action; and
   e. Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision.

3) Appeal:

If a reconsideration determination is adverse to the Member, the Member may request an appeal with his or her MCO in accordance with 8.305.12 NMAC.
4) HSD Administrative Hearings:

After the Member has exhausted the MCO appeal process, the Member may request an HSD administrative hearing in accordance with 8.352.2 NMAC.

5) State Administrative Hearing:

After the parties have exhausted the MCO appeal process, the parties may request an administrative hearing according to State administrative rule 8.352.2.

O. Communication Forms

The MCO shall use the approved HSD forms for communication and notification with the NFs.

See appendices for forms.

Appendix A: Nursing Facility Communication Form

Appendix B: Nursing Facility Notification Form
7 COMMUNITY BENEFIT

Revision Dates: January 1, 2014

Review Date: January 1, 2014

Initial Effective Date January 1, 2014

For members meeting nursing facility level of care, the MCO shall provide the Community Benefit as determined appropriate based on the CNA. Members eligible for the Community Benefit have the option of selecting Agency-Based or Self-Directed Community Benefit.

A. REGISTRATION FOR THE COMMUNITY BENEFIT FOR MEMBERS NOT OTHERWISE MEDICAID ELIGIBLE

1. PURPOSE
   a. Describes the process to register individuals who request Community Benefit services; and
   b. Initiates the allocation process.

2. DEFINITIONS

   Agency Based Community Benefit (“ABCB”): Services that provide assistance to individuals that require long-term supports and services so they may remain in the family residence, in their own home or in community residences. This program serves as an alternative to a Nursing Facility (NF).

   Active Registration: A registration is active if there is either an open category of registration or a paper application is received by the New Mexico Aging & Long-Term Services Department, Aging and Disability Resource Center (“ADRC”).

   Activity of Daily Living (“ADL”): The ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting and transferring.

   Inactive Registration: A registration is inactivated/closed if the registrant expired, refused services, was allocated but notice was undeliverable or the registrant moved out of state.

   MAD 100: New Medicaid application for assistance that is available on-line or at a local New Mexico Department of Human Services, Income Support Division (“HSD/ISD”) office.
MAD 325: Waiver of Services Registration application that is available at a local HSD/ISD office.

Needs Assistance: Registrant needs cuing, reminding and/or stand-by assistance.

3. REGISTRATION
   a. Any individual has the right to sign-up for the Central Registry if: (1) it has been determined that the individual is not currently Medicaid eligible, (2) current Medicaid shows a termination date, or (3) the individual has applied for Medicaid and received a denial. At the time of registration, if the individual has a Medicaid category of eligibility entitling the individual to full Medicaid benefits, ADRC shall refer the individual to his/her managed care organization (“MCO”).

   b. Any individual has the right to register/apply for multiple waivers at the same time; however, Brain Injury (“BI”) registrants have an age restriction of 65 years of age or younger. If a BI registrant turns 65, the ADRC shall call and conduct the pre-assessment to determine a new category of registration.

   c. An individual must be a resident of the State of New Mexico in order to be registered. Residency is determined using the State’s Medicaid eligibility.

   d. For purposes of establishing eligibility for the Community Benefit services, a waiver or waivers are those approved by the Centers for Medicare & Medicaid Services (“CMS”) for the State of New Mexico for Medicaid benefits.

   e. Individuals may apply by calling or appearing in person to the ADRC or by filling out a New Mexico Human Services Department (“HSD”), Medical Assistance Division (“HSD/MAD”) 325 Waiver of Services Registration Application at their local HSD/ISD office.

   f. Individuals should note that the Central Registry records such information as: (1) the demographic information about the applicant; (2) the date of registration, and (3) the applicant’s specific needs.

   g. Individuals are also required to complete a pre-assessment which aids the ADRC staff in directing the applicant to the appropriate category of registration: Regular, Expedited, Community Reintegration, or Brain Injury, which are defined as:

      i. Brain Injury (“BI”) – a registrant who is self-described as having a brain injury or describes his/her injuries in such a way that the ADRC staff believes the registrant may have a brain injury. The registrant must be less than 65 years of age at the time of ISD eligibility determination (financial eligibility).

      ii. Community Reintegration (“CRI”) – a registrant who is in a licensed skilled nursing facility (“SNF”) at the time of registration. In order to be eligible for CRI, the registrant must have resided in a SNF for 90 consecutive days, which may include time the registrant was in a hospital and returned to the SNF without
a break in service. CRI provides individuals the opportunity to move out of a SNF and back into the community.

iii. Expedited (“EXP”) – a registrant who has an urgent need for care. To be eligible, the registrant must require total assistance in at least three (3) categories of ADLs and a minimum score of 48 points on the assessment. If an individual receiving Community Benefits has his or her Medicaid eligibility terminated, he or she can call the ARDC and request an expedited registration.

iv. Regular (“REG”) – a registrant who does not meet the criteria for BI, CRI or EXP.

4. THE ALLOCATION PROCESS
   a. The ADRC manages the Central Registry.
   b. The HSD/MAD manages the allocation process. The HSD/MAD Director determines allocation frequency based on available funding.
   c. In order to facilitate the allocation process, the ADRC shall:
      i. Maintain accurate registrant information in the Central Registry, including coding of category of registration for each registrant.
      ii. Change a registrant’s category of registration if the ADRC obtains information that justifies the change, e.g., a registrant leaves a SNF before the 90-day requirement is met.
      iii. Close/Deactivate a registration in accordance with the closing of an allocation as described herein.
   d. HSD/MAD shall maintain a list of registrants with the category of registration, sorted by the date of registration.
   e. When the HSD/MAD Director determines that an allocation should be made, the allocation process begins with the Letter of Interest (“LOI”) packet being sent to the registrant. The registrant is notified that there is an allocation available and is asked to respond by returning a completed Primary Freedom of Choice Form (“PFOC”). The LOI packet shall contain:
      i. LOI;
      ii. PFOC, attachment A;
      iii. Refusal of Services, attachment B; and
      iv. Return envelope addressed to HSD/MAD, stamped with “Allocation Packet.”
   f. Time frames for the LOI packet:
      i. The registrant has 45 calendar days to return either a completed PFOC or a Refusal of Services form.
      ii. The registrant may request a one-time extension and, if requested, it shall be granted for up to thirty (30) calendar days. Any additional time (extensions) requested by the registrant must be approved by HSD/MAD.
iii. If there is no response to the LOI either after the original 45-days or after the expiration of any granted extensions, HSD/MAD shall send a closure letter to the registrant’s mailing address on file with a copy to ADRC.

g. Processing PFOCs. Once HSD/MAD receives the PFOC, HSD/MAD will sort and review the PFOCs to ensure that the form is complete and signed by the registrant.
   i. If the PFOC is not complete or accurate, the PFOC will be returned to the registrant, identifying the correct information required to process the PFOC, and providing the registrant up to thirty (30) calendar days to return the PFOC. Failure to timely return the PFOC within the 30-day time period will result in closure as described herein.
   ii. If the PFOC is complete, HSD/MAD will process it and send a Notice of Allocation (“NOA”) letter to the registrant, with a copy of the PFOC and an HSD/MAD 100-Medicaid application for assistance. In addition, a copy of the NOA, PFOC and cover sheet is faxed to the registrant’s local HSD/ISD office and to the registrant’s MCO.

5. **ELIGIBILITY**
   a. Registrants must meet two (2) types of eligibility initially and annually to receive and continue receiving Community Benefits:
      i. Medical Eligibility. The medical eligibility packet is completed by the registrant’s MCO. In order to be medically eligible, the registrants must meet nursing facility level of care (NF LOC), which is, at a minimum, daily hands-on assistance with two or more ADLs.
      ii. Financial Eligibility. In order to be financially eligible, income must be under the Institutional Medicaid (ICM)/Waiver maximum determined by HSD/ISD.

   b. The registrant must complete both the medical and financial eligibility within ninety (90) calendar days from the allocation date stated in the NOA. Failure to complete both the medical and financial eligibility within the 90-day time period shall result in closing the allocation.

   c. Once eligibility is approved, registrants will be enrolled with ABCB services and shall receive such services as are needed, based on the Comprehensive Needs Assessment (“CNA”) conducted by the member’s MCO. Thereafter, the registrant shall be considered a member entitled to Community Benefits.

   d. The member must participate in the ABCB for a minimum of 120 calendar days before the member can switch to the Self-Directed Community Benefit (“SDCB”).

6. **CLOSING/INACTIVATING AN ALLOCATION**
   An allocation will be closed by HSD/MAD if one of the following occurs:

   a. The registrant returns a signed Refusal Form;
   b. The registrant does not return the LOI or the PFOC within the required timeframes;
c. The ADRC or HSD/MAD is informed that the registrant intends to remain in the SNF;
d. The ADRC or HSD/MAD is informed that the registrant is no longer a resident of the State of New Mexico;
e. The ADRC or HSD/MAD has been notified that the registrant has expired; or
f. The LOI is returned as undeliverable and no other contact information is available.

7. NOTICE REQUIREMENTS
The registrant is notified by letter in the following circumstances:

a. New registration;
b. Change in category of registration;
c. When the State is unable to contact the registrant by telephone;
d. When an allocation becomes potentially available for the registrant;
e. When an allocation is complete; and
f. When a registration is closed/inactivated for any reason other than a completed allocation, with the exception of when the State has been notified that the registration has expired. In such a situation, no letter will be sent to the registrant.

8. UNDELIVERABLE NOTICE
It is the registrant’s responsibility to keep ADRC informed of any change in address and/or telephone number. If a letter is returned to the State as undeliverable, HSD/MAD shall review the registrant record to determine an alternate address. HSD/MAD shall attempt to call the registrant or the registrant’s representative to verify a correct mailing address to send notice. If HSD/MAD cannot obtain the registrant’s address, the registrant’s Central Registry record will be closed due to inability to contact the registrant. HSD/MAD shall document the reason the registration is closed, the attempts made to contact the registrant and the date(s) in the registrant’s journal notes.

B. AGENCY BASED COMMUNITY BENEFIT

Members selecting the Agency-Based model have the choice of the consumer delegated or consumer directed models for personal care services.

1. Agency Based Community Service Standards
These standards apply to the services provided through the Medicaid 1115 Waiver for individuals who meet the eligibility criteria for Agency Based Community Benefit Services (ABCB). These standards clarify, interpret, and further enforce the Human Services Department regulations 8.308.12 NMAC, effective January 1, 2014.

These standards are effective January 1, 2014. The standards address each service covered by the ABCB. Individuals served through this program will expect to receive services that meet these standards.
These standards define the services offered as approved by the Centers of Medicare & Medicaid (CMS). The ABCB services are a supplement to the member’s natural supports and are not intended to replace family support. The ABCB is not a twenty-four hour service. The services are designed to increase independence and achieve personal goals while providing care and support to enable individuals to live as active members of the community while ensuring health and safety. The purpose of this program is to provide assistance to individuals that require long-term supports and services so they may remain in the family residence, in their own home or in community residences. This program serves as an alternative to a Nursing Facility (NF). The ABCB services are implemented in accordance with the Care Plan as developed with the member and the MCO Care Coordinator (CC).

2. Definitions
   a. ADULT: Individuals who are age twenty-one (21) years or older.
   b. ALLOCATION: Funding becomes available to serve additional individuals on the 1115 waiver who are not otherwise Medicaid eligible.
   c. ANNUAL: The 12-month period covered by a Care Plan, except where otherwise stated.
   d. APS: Adult Protective Services Division of the Aging and Long-Term Services Department.
   e. CARE COORDINATOR: The individual responsible for coordinating services with members in the managed care program.
   f. CHILD: Is an individual under the age of 21.
   g. CLINICAL NECESSITY: Health care services that a Healthcare Provider, exercising (a) clinical decisions made on behalf of an individual in a manner which result in the rendering of necessary, safe, effective, appropriate clinical services; (b) clinical decisions that result in the appropriate clinical intervention considering the severity and complexity of symptoms; (c) decisions that result in the rendering of clinical interventions consistent with the diagnosis and are appropriate for the member’s response to the clinical intervention; (d) decisions rendered in accordance with the provider’s professional scope of license or scope of practice regulations and statutes in the state where the provider practices.
   h. COMMUNITY RE-INTEGRATION: Provides individuals the opportunity to move out of a skilled nursing facility after a 90 continuous day stay, back into the community.
   i. CYFD: Children Youth and Family Department.
   j. FACE -TO - FACE: Being in the physical presence of the individual who is receiving services.
   k. FREEDOM OF CHOICE: A form that provides the member opportunities to select their choice for delivery of services as identified on the Care Plan.
l. HEALTH CARE PLAN: A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the individual. The Health Care Plan is developed and monitored by a nurse.
m. HSD: Human Services Department, New Mexico Human Services Department.
n. IDT: Interdisciplinary Team, consisting of the member, the legally authorized representative, the family, service providers and other people invited by the member and the legal authority representative, if applicable.
o. IMMEDIATE FAMILY MEMBER: Father (includes natural or adoptive father, father-in-law, stepparent), mother (includes natural or adoptive mother, mother-in-law, stepparent), brother (includes half-brother, step-brother), sister (includes half-sister, step-sister), son or daughter, step-son or step daughter, adoptive son or daughter, natural grandfather, and natural grandmother and spouse relationship to the individual.
p. INCIDENT REPORT (IR): Required form for documenting all reportable incidents of abuse, neglect, exploitation, death, expected and unexpected, environmental hazard, law enforcement intervention and emergency services.
q. ISD: Income Support Division, New Mexico Human Service Department.
r. LOC: Level of Care, an instrument used in determining the level of care (medical eligibility) for Community Benefit Services and for institutional care.
s. LTCMA: Long-Term Care Medical Assessment (ISD 379 form).
t. MAD: The Medical Assistance Division, New Mexico Human Services Department.
u. NATURAL FAMILY MEMBER: A person related by blood or adoption to include: mother, father, brother, sister, aunt, uncle, grandmother, grandfather, son, or daughter.
v. NATURAL HOME: Residence of the individual or the primary caregiver.
w. NATURAL SUPPORTS: Supports not paid for with Medicaid funds that assist the individual to attain the goals as identified on the Care Plan. Individuals who provide natural supports are not paid staff members of a service provider, but they may be planned, facilitated, or coordinated in partnership with a provider.
x. NON MEDICAL HEALTH CARE: Promotion of or assistance with minor health needs; e.g. with minor cuts and scrapes, using menstrual supplies, or hygiene to promote health (e.g. denture cleaning).
y. PARENT: Natural or adoptive mother or father, or stepmother, stepfather.
z. PLAN OF CARE: A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the individual. Form SCMS-485.
aa. PRIMARY CAREGIVER: Parent or surrogate parent providing day-to-day care of an individual.
bb. RELATIVES: Immediate family members such as the parent of an adult, a sibling, grandparent, aunt, uncle, etc. but not the parent of a minor child or a spouse.
c. SUPPORT: Assistance to an individual that may or may not include a paid service.
3. ABCB COVERED SERVICES

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 in the Care Plan. 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, by 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.

1. SCOPE OF SERVICES

a. The health, safety and welfare of the member must be the primary concern of all activities and services provided. Program staff must supervise all activities. Specific services may include the following:
   1. Coordination of transportation to and from the Adult Day Health center;
   2. Activities that promote personal growth;
   3. Activities that enhance the member’s self-esteem by providing opportunities to learn new skills and adaptive behaviors;
   4. Supervision of self-administrated medication as determined by the New Mexico Nurse Practice Act;
   5. Activities that improve capacity for independent functioning;
   6. Activities that provide for group interaction in social and instructional programs and therapeutic activities;
   7. Personal care services;
   8. Meals that do not constitute a “full nutritional regime” of three (3) meals per day;
   9. Intergenerational experiences;
   10. Involvement in the greater community; and
   11. Providing access to community resources as needed.
b. Activities shall be planned by the member, family, caregivers, volunteers, staff and other interested individuals and groups.

c. The provider must assure safe and health conditions for activities inside or outside the facility.

d. An interdisciplinary team meeting for each member will occur at least quarterly to review ongoing progress of direct services and activities. The Plan of Care will be adjusted as necessary to meet the needs of the member at the quarterly meeting or at other times as needed.

e. An Individual Plan of Care will be developed with identified goals and measurable objectives. It will be attached to or incorporated in the Care Plan.

f. All activities must be supervised by program staff.

g. Members must never be left unattended. An Adult Day Health center staff member must be physically present with the member(s) at all times.

h. Activities must be designed to meet the needs of the member and enhance the member’s self-esteem by providing opportunities to:
   i. Learn new skills and adaptive behaviors;
   ii. Improve or maintain the capacity for independent functioning; and
   iii. Provide for group interaction in social and instruction programs and therapeutic activities.

2. AGENCY PROVIDER REQUIREMENTS

a. Adult day health services may be provided by eligible adult day health agencies.

b. Adult day health facilities must be licensed by Department of Health (DOH) as an adult day care facility pursuant to 7 NMAC 13.2.

c. Adult day health facilities must meet all requirements and regulations set forth by DOH as an adult day care facility pursuant to 7 NMAC 13.2.

d. Adult Day Health Centers must comply with the provisions of Title II and III of the American’s with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).

e. Adult Day Health Centers must comply with all applicable cities, county or state regulations governing transportation services.

f. Must comply to the Human Services Department, Medical Assistance Division (HSD/MAD) requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.

g. Adult Day Health Centers must make appropriate provisions to meet the needs of adults who require special services as indicated in the member’s Care Plans.

h. The MCO will provide a copy of the Care Plan to the Adult Day Health Services Provider.
i. A written Adult Day Health Services Plan of Care (POC) will include the assessment of the special needs, the interventions to meet those needs, evaluation of the plan, with changes as needed. The POC will be provided to the MCO Care Coordinator and must be incorporated into the member’s Care Plan.

j. The provider must be culturally sensitive to the needs and preferences of the member. Communicating in a language other than English may be required.

3. **REIMBURSEMENT**

Billing is on an hourly basis and is accrued to the nearest quarter of an hour. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable. Reimbursement for adult day health services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review the prior authorizations issued from the MCO to assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. **LIMITS or EXCLUSIONS**

A minimum of two hours per day for one or more days per week.
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.

1. SCOPE OF SERVICES:
   a. Core services provide assistance to the member in meeting a broad range of activities of daily living. Specific services may include the following:
      i. Personal Hygiene;
      ii. Dressing;
      iii. Eating;
      iv. Socialization;
      v. Opportunities for individual and group interaction;
      vi. Housekeeping;
      vii. Laundry;
      viii. Transportation;
      ix. Meal preparation and dining;
      x. Twenty-four (24) hour, on-site response capability to meet scheduled or unpredictable participant needs;
      xi. Capacity to provide on-going supervision of the ABCB member within a twenty-four (24) hour period;
      xii. Coordination of access to services not provided directly;
xiii. Participation in the Interdisciplinary Team meetings for development of the Care Plan;

xiv. Implementation of the plan to meet the needs, evaluation for effectiveness, and adaptation as needs change.

b. Services provided to a resident of an Assisted Living program are pursuant to the Care Plan, developed by the recipient of services and the MCO care coordinator.

c. Direct services provide assistance to the member in meeting a broad range of activities of daily living. Direct service provision may be provided by the Assisted Living Facility or may be provided by another approved provider. The direct care providers must be identified on the member’s Care Plan and the Assisted Living Plan of Care, that is separate from the CP, and might include:

i. Private Duty Nursing services for Adults (see the ABCB Service Standards for Private Duty Nursing).

ii. Skilled Maintenance Therapies for Adults (see the ABCB Service Standards for Skilled Maintenance Therapies).

iii. The cost of room and board is not a covered service in Assisted Living.

2. PROVIDER QUALIFICATIONS

a. Assisted Living Services must be provided in the following facilities or environmental settings: Adult Residential Care Facilities – licensed by Licensing and Certification Bureau, Division of Health Improvement/Department of Health. Adult Residential Care Facilities must meet all requirements set forth by the Licensing and Certification Bureau Department of Health. This would include the definition of a “home-like” and the environment found in Section III of this document.

b. Provider agencies must meet the minimum, applicable qualifications set forth by the Licensing and Certification Bureau of the Department of Health and HSD/MAD, including but not limited to: Labor Laws and Regulations, Criminal Background Checks, Employ Abuse Registry, Incident Management reporting, OSHA training requirements, etc.

c. Provider agencies must comply with the provisions of Title II and III of the American’s with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).

d. Provider agencies must comply with ensuring personnel providing direct services meet all certification standards established by HSD/MAD for personal services, private duty nursing and skilled maintenance therapies (see ABCB Service standards for each separate service especially the qualifications required i.e. nursing requires a license etc.).

e. Providers of Assisted Living are required to maintain staffing ratios and patterns that will meet the individual members’ needs as identified in the Care Plans and the agency’s Individual Plans of Care.
f. The Assisted Living program will develop a Plan of Care for each member based on the assessment of the needs of the member, and include strategies to meet those needs. The Plans of Care must be evaluated for effectiveness, and revised as the needs of the members change. The Plan of Care is separate and incorporated into the Care Plan.

g. The Assisted Living provider will develop a written agreement with each ABCB member residing in their assisted living facility. This agreement will detail all aspects of care to be provided including identified risk factors. It will also include the financial agreement regarding the cost of room and board and the funding sources. A copy of this agreement and any later revisions must be forwarded to the MCO care coordinator. The original is maintained in the member’s file at the assisted living residence.

h. Definition of “Home-Like” Environment.

A “home-like” environment must possess the following structural features prior to the placement of the ABCB services recipient. Meeting these requirements is the financial responsibility of the Assisted Living Provider:

1. A minimum of 220 square feet of living space, including kitchen space for newly constructed units. Rehabilitated units must provide a minimum of 160 square feet of living space;
2. A minimum of 100 square feet of floor space in each single bedroom. Closet and locker areas shall not be counted as part of the available floor space. Members must have access to a separate common living area, kitchen and bathroom that are all accessible for persons with a disability;
3. A minimum of 80 square feet of floor space per member in a semi-private bedroom (sharing a bedroom is the member’s choice only). Closet and locker areas shall not be counted as part of the available floor space. Members must have access to a separate common living area, kitchen and bathroom that are all accessible for persons with a disability;
4. Kitchens must be furnished with a sink, a refrigerator, at least a two burner stove top or 1.5 cubic foot microwave oven;
5. Each unit must be equipped with an emergency response system;
6. Common living areas must be smoke free; and
7. Floor plans must be submitted to the HSD/MAD along with the Medicaid Provider Participation Application or renewal.

3. REIMBURSEMENT
   a. The billable unit rate for Assisted Living services is based on a daily rate.
   b. Room and Board
      i. The Agency Based Community Benefit does not reimburse for room and board costs for the member (such as rent, groceries, etc.).
ii. Room and board rates billed to the ABCB services must be reported to the HSD/MAD along with the Medicaid Provider Participation Agreement application and renewal prior to the provision of assisted living services by the provider agency. Any subsequent changes to those rates must also be forwarded to the HSD/MAD when they occur.

iii. The provider agency must comply with all state and federal guidelines regarding the establishment of room and board rates to the ABCB services recipients.

iv. Training on member specific issues is reimbursable.

c. Non Billable Activities

i. The Assisted Living Services provider will not bill MCO for Room and Board.

ii. General training requirements are an administrative cost and not billable.

iii. The Provider will not bill when an individual is hospitalized or in an institutional care setting.

4. LIMITS or EXCLUSIONS

Assisted Living services will not include the following ABCB services: Personal care, Respite, Environmental Modifications, Emergency Response or Adult Day Health. This is because the Assisted Living Program is responsible for all of these services at the Assisted Living facility. Therefore provision of these services in addition to the Assisted Living would constitute duplication of services.
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 participant with a developmental disability and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the participant 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.

1. SCOPE OF SERVICES

Behavior support consultation services are initiated when the MCO Care Coordinator identifies and recommends the service be provided to the member/member’s representative. The Care Coordinator is responsible for including recommended units of behavior support consultation services. It is the responsibility of the participant/participant representative, and Care Coordinator, to assure units of therapy do not exceed the capped dollar amount determined for the participant/participant representative’s Level of Care (LOC) and Care Plan cycle. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns and priorities in the Care Plan.

a. Behavior Support Consultation Services Include:
   i. Providing assessments, evaluations, development of treatment plans and interventions, training, monitoring of the participant/participant representative, and planning modification as needed for therapeutic purposes within the professional scope of practice of the BSC.
   ii. Designing, modifying and monitoring the use of related activities for the participant/participant representative that is supportive of the Care Plan.
   iii. Training families and DSPs in relevant settings as needed for successful implementation of therapeutic activities, strategies, and treatments.
   iv. Consulting with the Interdisciplinary Team (IDT) member(s), guardians, family, or support staff.
   v. Consulting and collaborating with the participant/participant representative’s primary care provider (PCP) and/or other therapists and/or medical personnel for the purposes of evaluation of the participant or developing, modifying or monitoring behavior support consultation services for the participant.
   vi. Observing the participant/participant representative in all relevant settings in order to monitor the participant’s status as it relates to therapeutic goals or implementation of behavior support consultation services and professional recommendations.
vii. Services may be provided in a clinic, home, or community setting.

b. Comprehensive Assessment Guidelines:
   i. The BSC must perform an initial comprehensive assessment for each participant to give the appropriate behavior support recommendations, taking into consideration the overall array of services received by the participant. A comprehensive assessment must be done at least annually and when clinically indicated.

c. Attendance at the IDT Meeting:
   i. The BSC is responsible for attending and participating, either in person or by conference call in IDT meetings convened for service planning.
   ii. If unable to attend the IDT meeting, the BSC is expected in advance of the meeting to submit recommended updates to the strategies, support plans, and goals and objectives. The BSC and MCO Care Coordinator will follow up after the IDT meeting to update the BSC on specific issues.
   iii. The BSC must document in the participant’s clinical file the date, time, and any changes to strategies, support plans, and goals and objectives as a result of the IDT meeting.

d. Discharge Planning Documentation Includes:
   i. Reason for discontinuing services (such as failure to participate, request from participant/participant representative, goal completion, and/or failure to progress).
   ii. Written discharge plan shall be provided to the participant/participant representative and the MCO Care Coordinator by the BSC.
   iii. Strategies developed with participant/participant representative that can support the maintenance of behavioral support activities.
   iv. Family and direct support professional training that is completed in accordance with the written discharge plan.
   v. Discharge summary is to be maintained in the clinical participant file maintained by the BSC and a copy is to be sent to the MCO Care Coordinator and distributed to the participant/participant representative.

2. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

All BSCs who are working independently, or as sub-MCOs, or as employees of a provider agency who offer behavior support consultation services shall meet all the requirements of the ABCB Service Standards.

The agency must maintain a current provider status through the HSD/MAD Provider Enrollment Unit. Contact Provider Enrollment Unit for details.

3. AGENCY/INDIVIDUAL ADMINISTRATIVE REQUIREMENTS

a. BSC Requirements:
i. Master’s degree from an accredited school for psychology, social work, counseling or guidance program and maintain current license as required by New Mexico State Law.

ii. Acceptable licensure includes:
   - New Mexico Licensed Psychologist or Psychologist Associate.
   - New Mexico Licensed Independent Social Worker (LISW).
   - New Mexico Licensed Master Social Worker (LMSW).
   - New Mexico Licensed Clinical Counselor (LPCC).
   - New Mexico Licensed Marriage and Family Therapist (LMFT).

iii. Maintain a culturally sensitive attentiveness to the needs and preferences of participants and their families based upon culture and language. Communicating in a language other than English may be required.

iv. Licensed BSCs identified in Section III. A. of this document may provide billable behavior support consultation services.

b. Documentation:

i. Documentation must be completed in accordance with applicable HSD/MAD and federal guidelines.
   - All documents are identified by title of document, participant name, and date of documentation. Each entry will be signed with appropriate credential(s) and name of person making entry.
   - Verified Electronic Signatures may be used. BSC name and credential(s) typed on a document is not acceptable.
   - All documentation will be signed and dated by the BSC providing services.
   - A copy of the annual evaluation and updated treatment plan will be provided to the MCO Care Coordinator within 10 business days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable.

ii. BSC progress/summary notes will include date of service, beginning/end time of service, location of service, description of service provided, participant/family/DSP response to service, and plan for future service.

iii. The summary will include the number and types of treatment provided and will describe the progress toward BSC goals using the parameters identified in the initial and annual treatment plan and/or evaluation.

iv. Any modifications that need to be included in the Care Plan must be coordinated with the MCO Care Coordinator.

v. Complications that delay, interrupt, or extend the duration of the program will be documented in the participant's medical record and in communications to the Physician/Healthcare provider as indicated.
vi. Each participant will have an individual clinical file maintained by the provider.

vii. Review Physician/Healthcare provider orders at least annually and as appropriate, and recommend revisions on the basis of evaluative finding.

viii. Copies of BSC contact notes and BSC documentation may be requested by HSD/MAD for assurance purposes.

4. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies the provider’s role in all components of the provision of care, including assessment information, care planning, intervention, communications, and care coordination and evaluation. There must be justification in each member’s clinical record supporting medical necessity for the care and for the approved LOC that will also include frequency and duration of the care. All services must be reflected in the Care Plan that is coordinated with the participant/participant representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and authorized by the approved authorization. Payment for behavior support consultation services through the MCO is considered payment in full. Reimbursement for BSC services will be based on the negotiated rate. Service providers have the responsibility to review and assure that the information on the prior authorization for their services is current. If the provider identifies an error, they will contact the MCO immediately to have the error corrected. HSD/MAD does not consider the following to be professional BSC duties and will not authorize payment for:

a. Performing specific errands for the participant/participant representative or family that is not program specific.
b. Friendly visiting, meaning visits with the participant outside of work scheduled.
c. Financial brokerage services, handling of participant finances or preparation of legal documents.
d. Time spent on paperwork or travel that is administrative for the provider.
e. Transportation of participant/participant representative.
f. Pick up and/or delivery of commodities.
g. Other non-Medicaid reimbursable activities.
COMMUNITY REINTEGRATION

The individual participating in the community re-integration process must be capable of comprehending the decisions being made or have a primary caregiver or legal surrogate that understands the options. The individual must not require Agency Based Community Benefit (ABCB) services 24 hours per day in his/her home, on an ongoing basis; as the intent of this process is to assist the individual to become integrated into their community as independent as possible. MCO must be able to ensure a reasonable level of health and safety for the member while ABCB services are being provided. ABCB services provided to these individuals must be cost-effective. Services provided under the ABCB must not exceed the average annual per capita costs of Nursing Facility services. HSD/MAD can refuse ABCB services to individuals whose health and safety would be at risk in the community as deemed by the interdisciplinary team which would include the MCO, the primary care physician, service providers in conjunction with a technical assistance with HSD/MAD.

Community Re-integration Registration for the ABCB can be completed by calling the Aging and Disability Resource Center (ADRC). Once a 90 continuous day stay is confirmed by the HSD/MAD and funding is available, a community re-integration allocation is granted. The HSD/MAD sends the allocation packet to the registrant/representative. The allocation paperwork (Primary Freedom of Choice form PFOC) must be returned to the HSD/MAD within 45 calendar days or the allocation will be closed and the registrant would need to re-register and wait for another allocation. If an extension is needed, HSD/MAD must be notified to grant the extension.

Once the PFOC is received by the HSD/MAD, it is faxed to the local Income Support (ISD) office. It is also faxed to the MCO. Once the allocation has been granted, the registrant may leave the nursing home if a safe and appropriate discharge is arranged.

The MCO must contact the registrant within 5 business days of receipt of the PFOC to schedule an initial assessment. The assessor explains the Community Reintegration process to the applicant/representative. If the registrant/representative wishes to remain in the institution, the Waiver Refusal Form must be completed, signed and faxed to HSD/MAD. If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.

Once medical and financial eligibility is approved, ABCB services will be initiated.
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. The member’s name must be on the lease, deed or rental agreement. 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. Services must be reasonable and necessary as determined by the MCO and authorized in the Care Plan.

1. SCOPE OF SERVICES
Community transition services must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

a. Security deposits that are required to obtain a lease on an apartment or home. Monthly rental or mortgage expenses are not covered; therefore, the member should have sufficient resources to pay for the first month’s rent or mortgage as well as ongoing rent or mortgage costs.
b. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
c. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
d. Services necessary for the individual’s health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy;
e. Moving expenses, and
f. Fees to obtain a copy of birth certificate, identification card or driver’s license.

2. AGENCY PROVIDER REQUIREMENTS
The Community Transition Services may be provided directly by the MCO or contracted out to an outside Community Transition Agency (CTA). The CTA is defined as an agency that provides community transition services to individuals who are transitioning from a nursing facility to a home and community-based residence. The CTA must be able to provide at least two of the following core services:

a. Information and referral
b. Independent living skills training  
c. Peer counseling  
d. Individual and systems advocacy  
e. Community transition agencies include but are not limited to Centers for Independent Living and Area Agencies on Aging.

3. REIMBURSEMENT  
Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

Reimbursement for community transition services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review the prior authorizations issued from the MCO to assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS or EXCLUSIONS  
Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, household appliances or items that are intended for purely diversional/recreational purposes.

Additional exclusions: music systems, cable/internet, TV, VCR, DVD, MP3 player, telephone equipment, computer, exercise equipment, personal hygiene items, decorative items, experimental or prohibited treatments and memberships.

Community Transition Services are limited to $3,500.00 per person every five years. In order to be eligible for this service, the person must have a nursing facility stay of at least 90 days prior to transition to the community.
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.

1. SCOPE OF SERVICES
   a. Services provided by emergency response systems:
      i. Installation, testing and maintenance of equipment.
      ii. Training on the use of the equipment to members/caregivers and first responders.
      iii. 24-hour monitoring for alarms.
      iv. Monthly systems check, or more frequently if electrical outages, severe weather systems, etc. warrant more frequent checks.
      v. Reports of member emergencies to the Care Coordinator and changes in the member’s condition that may affect service delivery.
   b. The response center must be staffed by trained professionals.
   c. Emergency response service categories consist of emergency response, emergency response high need.

2. AGENCY PROVIDER REQUIREMENTS
   a. Emergency Response Providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems, if applicable.
   b. Provider agencies must establish and maintain financial reporting and accounting for each member.
   c. Emergency Response Service Providers must provide the member with information regarding services rendered, limits of service, and information regarding agency service contracts. This information will also include whom to contact if a problem arises, liability for payment of damages over normal wear, and notification when change of service occurs.
   d. The agency will have security bonding.
   e. Emergency Response Service Providers must report emergencies and changes in the member’s condition that may affect service delivery to the Care Coordinator within 24 hours.
f. Emergency Response Service Providers must complete quarterly reports for each member served. The original report must be maintained in the member’s file and a copy must be submitted to the MCO Care Coordinator.

3. REIMBURSEMENT

   a. Reimbursement for emergency response services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

   b. A monthly fee charged for each calendar month of use ongoing through entirely of a contractual agreement.

   c. A fee for special equipment (e.g., is bracelet rather than a necklace) must be medically necessary and substantiated by the MCO. This is designated as Emergency Response – High Need.

4. LIMITS or EXCLUSIONS

   Eligible members must have a landline phone.
EMPLOYMENT SUPPORTS

Employment Supports include job development, job seeking and job coaching supports after available vocational rehabilitation supports have been exhausted. The job coach provides training, skill development, and employer consultation that an individual may require while learning to perform specific work tasks on the job; co-worker training; job site analysis; situational and/or vocational assessments and profiles; education of the eligible member and co-workers on rights and responsibilities; and benefits counseling.

The service must be tied to a specific goal specified in the individual’s care plan. Job development is a service provided to eligible members by skilled staff.

The service has five components: 1) job identification and development activities; 2) employer negotiations; 3) job restructuring; 4) job sampling; and 5) job placement.

Employment Supports will be provided by staff at current or potential work sites. When supported employment 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 eligible members receiving 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.

1. SCOPE OF SERVICES

Supported employment facilitates competitive work in integrated work settings for individuals with disabilities (i.e. psychiatric, mental retardation, learning disabilities, and traumatic brain injury) for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

a. Basic Components

Supported employment services should achieve the following outcomes: opportunity to earn equitable wages and other employment-related benefits, development of new skills, increased community participation, enhanced self-esteem, increased consumer empowerment, and quality of life. The types of supported employment services used depend on the needs of individual consumers. The following are the basic components of supported employment:

i. Paid Employment—Wages are a major outcome of supported employment. Work performed must be compensated with the same benefits and wages as other workers in similar jobs receive. This includes sick leave, vacation time, health benefits, bonuses, training opportunities, and other benefits.
ii. **Integrated Work Sites**--Integration is one of the essential features of employment supports. Members with disabilities should have the same opportunities to participate in all activities in which other employees participate and to work alongside other employees who do not have disabilities.

Members who are interested in pursuing work should discuss this with their MCO Care Coordinator and assure it is a goal within their plan. They should then be referred to Vocational Rehabilitation. No persons should request employment supports services through the ABCB program without utilizing the services of Vocational Rehabilitation Services. It is V.R.’s role to work with the person to develop an employment plan, assess abilities, and determine whether long term support is needed.

Employment Supports does not include sheltered work or other similar types of vocational services furnished in specialized facilities (federal guidelines). The employment setting needs to be in an integrated setting.

Members are still eligible for accessing Community Services in conjunction with Employment Supports.

2. **AGENCY PROVIDER REQUIREMENTS**
   a. Provider Agency Records: The provider adheres to the Department of Labor (DOL) wage laws and maintains required certificates and documentation. These documents are subject to review by the HSD/MAD. Each individual’s earnings and benefits shall be monitored by the Provider Agency in accordance with the Fair Labor Standards Act. Each individual’s earnings and benefits shall be reviewed at least semi-annually by the Supported Employment Provider to ensure the appropriateness of pay rates and benefits.
   b. The Provider Agency shall maintain a confidential case file for each individual and will include the following items:
      i. Quarterly progress reports;
      ii. Vocational assessments (A vocational assessment or profile is an objective analysis of a person’s interests, skills, needs, career goals, preferences, concerns, in areas that can pertain to an employment outcome and can ultimately be compared to the requirements and attributes of a potential job in order to determine the degree of compatibility as well as identification of training needs). A vocational assessment must be of a quality and content to be acceptable to DVR or HSD/MAD;
      iii. Career development plan as incorporated in the Care Plan; a career development plan consists of the vocational assessment and the Work/Learn Action Plan that specifies steps necessary towards a successful employment outcome and identifies the people who will complete specific tasks including the individual, as well and a review and reporting mechanism for mutual accountability.
c. Provider Agency Reporting Requirements:
   i. The Supported Employment Provider Agency shall submit the following to the CCMCO Care Coordinator:
   ii. Quarterly Progress Reports based upon the individual’s Care Plan cycle;
   iii. Vocational Assessment; and
   iv. Written updates, at least every six (6) months, to the Work/Learn Action Plan.

d. Training Requirements: Each Provider Agency shall retain staff trained to establish Career Development Plans. Training will be provided by the Provider Agency necessary to ensure that individuals are able to demonstrate competency in skills listed under these standards.

e. Staffing Requirements (Individual to Staff Ratio):
   i. The provider shall ensure adequate staffing to assure health, safety, and promote positive work behavior and growth. The amount of staff contact time shall be adequate to meet the individual’s needs and outcomes as indicated in the Care Plan and may vary according to purpose (e.g., job development, job training, job stabilization, career enhancement). For Individual Supported Employment, the staff to individual ratio is 1:1 unless otherwise specified in the Care Plan. For Individual Supported Employment, a minimum of 1 one-hour face-to face visit per month is required.
   ii. Staffing Restrictions: Agencies may not employ or sub-contract direct care personnel who are an immediate family member or who are a spouse of the individual served to work in the setting in which the individual is served.
   iii. Supervision: In a group employment setting, the provider determines the job site and is responsible for the day-to-day supervision of the individuals and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with his or her role as employer. When necessary and appropriate, the Supported Employment Provider Agency may supplement these services.

f. Qualification and Competencies for Employment Supports Staff: Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, are able to:
   i. Provide supports to the individual as contained in the Care Plan to achieve his or her outcomes and goals;
   ii. Employ job-coaching techniques and to help the individual learn to accomplish job tasks to the employer’s specifications;
   iii. Increase the individual’s capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
   iv. Identify and strengthen natural supports that are available to the individual at the job site and fade paid supports in response to increased natural supports;
v. Identify specific information about the individual’s interests, preferences and abilities;

vi. Effectively communicate with the employer about how to support the individual to success including any special precautions and considerations of the individual’s disability, medications, or other special concerns;

vii. Monitor and evaluate the effectiveness of the service and provide documentation that this information is effectively communicated to the MCO Care Coordinator and the IDT members through progress notes, quarterly reports, and participation in IDT meetings;

viii. Address behavioral, medical or other significant needs identified in the Care Plan that require intensive one-on-one staff support;

ix. Communicate effectively with the individual including communication through the use of adaptive equipment if applicable, at the work site;

x. Document information that pertains to Care Plan, progress notes, outcomes, and health and safety issues/concerns and any and all other required documentation by HSD.MAD;

xi. Adhere to relevant state policies/standards and Provider Agency policies and procedures that directly impact services to the individual;

xii. Model behavior, instruct and monitor any work place requirements to the individual;

xiii. Adhere to professionally acceptable business attire and appearance, and communicate through interactions a business-like, respectful manner; and

xiv. Adherence to the rules of the specific work place, including dress, confidentiality, safety rules, and other areas required by the employer.

3. REIMBURSEMENT

Employment Supports provider agencies must maintain appropriate record keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursements for Employment Support services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS or EXCLUSIONS

Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment
program. Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.
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.

1. SCOPE of SERVICE
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.

Environmental Modifications are managed by professional staff available to provide technical assistance and oversight to environmental modification projects. These modifications shall exclude those adaptations, improvements or repairs to the existing home that do not directly affect accessibility. Environmental Modifications excludes such things as carpeting, roof repair, furnace replacement, remodeling bare rooms, and other general household repairs.

a. Duplicate Adaptations: No duplicate adaptations, modifications or improvements shall be approved regardless of the payment source. For example, if the client has a safe and usable ramp, a replacement ramp shall not be approved.
b. New Construction: This service cannot be used to fund apartment buildings and Assisted Living facilities.

2. AGENCY PROVIDER REQUIREMENTS:
   a. The environmental modification provider must comply with all New Mexico state laws, rules and regulations, including applicable building codes.
b. The environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division GB02 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-3.
c. The environmental modification provider must provide a (1) one-year warranty from the completion date on all parts and labor.

d. The environmental modification provider must have a working knowledge of Environmental Modifications and be familiar with the needs of persons with functional limitations in relation to Environmental Modifications.

e. The environmental modification provider must ensure proper design criteria as addressed in planning and design of the adaptation.

f. The environmental modification provider must provide or secure licensed MCO(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects;

g. The environmental modification provider must provide consultation to family members, waiver providers and MCOs concerning environmental modification projects to the individual’s residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

h. The environmental modification provider must establish and maintain financial reporting and accounting for each member.

The environmental modification provider will submit the following information and documentation to the MCO:

i. Environmental modification evaluation;

ii. Service Cost Estimate. Photographs of the proposed modifications. The estimated start date of the work on the proposed modification; (equipment, materials, supplies, labor, travel, per diem, report writing time, and completion date of modification);

iii. Letter of Acceptance of Service Cost Estimate signed by the member;

iv. Letter of Permission from property owner. If the property owner is someone other than the member, the letter must be signed by the property owner and the member;

v. The Construction Letter of Understanding. If the property owner is someone other than the member, the letter must be signed by the property owner and the member;

vi. Documentation demonstrating compliance with the Americans with Disabilities Act (ADA).

i. The Provider must submit the following to the MCO, after the completion of work:

1. Letter of Approval of Work completed signed by the member; and

2. Photographs of the completed modifications.

j. The MCO must submit the following information to the provider:

1. Care Coordinator Individual Assessment of Need.

k. Note: ALTERNATIVES; The MCO shall first consider alternative methods of meeting the individual’s needs, since the MCO is the payer of last resort. This would include insurance, workman’s compensation, vocational rehabilitation, volunteer
organizations, etc. The MCO must include documentation that all other viable resources to fund the proposed modification have been contacted and refused.

3. REIMBURSEMENT
Environmental Modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on a project basis. One unit per modification project. Reimbursement for Environmental Modification services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS or EXCLUSIONS
a. Environmental modification services are limited to five thousand dollars ($5,000.00) every five (5) years.

b. Administrative Costs of the provider of the environmental modification services will not exceed fifteen percent (15%) of the total cost of the environmental modification project for each project managed by the MCO.
HOME HEALTH AID

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.

1. SCOPE of SERVICES
The Home Health Aide services assist the eligible member in a manner that promotes an improved quality of life and a safe environment for the eligible member. Home Health Aide services can be provided outside the eligible member's home. State Plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for eligible 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 perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records.

Home health aide services must be provided under the supervision of a registered nurse or other appropriate professional staff. The agency must make a supervisory visit to member's residence at least every two weeks to observe and determine whether goals are being met.

2. AGENCY PROVIDER REQUIREMENTS
   a. The Home Health Aide (HHA) Agency must be an approved provider with HSD/MAD.
   b. HHA Qualifications:
      i. HHA Certificate from an approved community based program following the HHA training federal regulations 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
      ii. HHA training at the licensed Home Health Agency which follows the federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;
      iii. A Certified Nurses’ Assistant (CNA) who has successfully completed the employing HH Agency’s written and practical competency standards and meets the qualifications for a HHA. Documentation will be maintained in personnel file.
      iv. A HHA who was not trained at the employing HH Agency will need to successfully complete the employing HH Agency’s written and practical
competency standards before providing direct care services. Documentation will be maintained in personnel file.

v. The HHA will be supervised by the HH Agency RN supervisor or HH Agency RN designee at least once every two weeks in the member’s home.

vi. The HHA will be culturally sensitive to the needs and preferences of the participants and their families. Based upon the individual language needs or preferences, HHA may be requested to communicate in a language other than English.

c. All supervisory visits/contacts must be documented in the member’s Home Health Agency clinical file on a standardized form that reflects the following:
   i. Service received;
   ii. Member’s status;
   iii. Contact with family members;
   iv. Review of HHA plan of care with appropriate modification annually and as needed.

d. Requirements for the HH Agency Serving ABCB Population:
   i. The HH Agency nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA.
   
   ii. The HH Agency staff will be culturally sensitive to the needs and preferences of participants and households. Arrangement of written or spoken communication in another language may need to be considered.

   iii. The HH Agency will document and report any noncompliance with the Care Plan to the MCO Care Coordinator.
   
   iv. All Physician orders that change the member’s service needs should be conveyed to the MCO Care Coordinator for coordination with service providers and modification to Care Plan if necessary.

   v. The HH Agency will document in the member’s clinical file that the RN supervision of the HHA occurs at least once every two weeks. Supervisory forms must be developed and implemented specifically for this task.

   vi. The HH Agency and MCO Care Coordinator must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care.

   vii. The HH Agency supervising RN, direct care RN and LPN shall train families, direct support professionals and all relevant individuals in all relevant settings as needed for successful implementation of therapeutic activities, strategies, treatments, use of equipment and technologies or other areas of concern.

   viii. It is expected the HH Agency will consult with, Interdisciplinary Team (IDT) members, guardians, family, and direct support professionals (DSP) as needed.
3. REIMBURSEMENT
Home Health Aide provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for home health aide services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
PERSONAL CARE SERVICES (PCS)

1. SCOPE of SERVICE:
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. This policy describes PCS for consumers who meet NF LOC because of disability or functional limitation and need assistance with certain ADLs and instrumental activities of daily living (IADLs).

   a. The MCO determines medical LOC for PCS eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the managed care organization (MCO) to apply for PCS.
   b. The goals of PCS are to avoid institutionalization and to maintain the consumer’s functional level and independence. Although a consumer’s assessment for the amount and types of services may vary, PCS are not provided 24 hours a day.
   c. PCS is a Medicaid service, not a Medicaid category of assistance, and services are delivered pursuant to an Individual Plan of Care (IPoC). PCS include a range of ADL and IADL services to consumers who meet NF LOC because of a disability or functional limitation(s). Consumers will be assessed for services at least annually, or more frequently, as appropriate. PCS will not include those services for tasks the individual is already receiving from other sources such as tasks provided by natural supports. Natural supports are friends, family, and the community (through individuals, clubs and organizations) that are able and consistently available to provide supports and services to the consumer. The Comprehensive Needs Assessment (CNA) is conducted pursuant to the managed care service agreement. The CNA is performed by the MCO and determines the amount and type of services needed to supplement the services a consumer is already receiving including those services provided by natural supports. PCS must be related to the individual’s functional level to perform ADLs and IADLs as indicated in the CNA.

2. ELIGIBLE POPULATION:
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/mentally retarded (ICF/MR) Medicaid, PACE, or Adult Protective Services attendant care program, at the time PCS are furnished; an individual residing in a NF or ICF/MR 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 an
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.

3. LEVEL OF CARE (LOC) DETERMINATION:
To be eligible for PCS, a consumer must meet the LOC required in a NF. The MCO
makes initial LOC determination and subsequent determinations at least annually
thereafter.

a. The MCO approves the consumer’s LOC for a maximum of one year (12
consecutive months); a new LOC determination must be made at least annually to
ensure the consumer continues to meet medical eligibility criteria for PCS; each
LOC determination must be based on the consumer’s current medical condition
and need of service(s), and may not be based on prior year LOC determinations;
the approved NF LOC has a start date and an end date of no more than 12
consecutive months, which is the NF LOC span.
b. Any individual applying for PCS who has an existing approved NF LOC
determination in another program (i.e., nursing facility) will not need an
additional LOC determination until his/her next annual assessment.
c. A PCS agency that does not agree with the LOC determination made by the MCO
or Medicaid’s designee may work with the consumer’s physician or physician
designee to request a re-review or reconsideration from the MCO.
d. A member that does not agree with the LOC determination made by the MCO
may file a grievance or appeal with the MCO. The MCO grievance or appeal
process must be exhausted before the consumer may request a fair hearing with
HSD pursuant to 8.352.2 NMAC, Recipient Hearings.
e. The MCO shall review the LOC determination upon a referral from the PCS
agency, the consumer, or the consumer's legal representative when a change in the
consumer's health condition is identified and make a new determination, if
appropriate.

4. SERVICE DELIVERY MODELS:
a. Consumers eligible for PCS have the option of choosing the consumer-delegated
or the consumer-directed personal care model. In both models, the consumer may
select a family member (except the spouse), a friend, neighbor, or other person as
the attendant. In the consumer-delegated model, the consumer chooses the PCS
agency to perform all employer-related tasks and the agency is responsible for
ensuring all service delivery to the consumer. The consumer-directed model allows the consumer to oversee his/her own service care delivery, and requires that the consumer work with a PCS agency acting as a fiscal intermediary agency to processing all financial paperwork to be submitted to the MCO. The MCO’s care coordinator is responsible for explaining both models to each consumer, initially, and annually thereafter.

5. CONSUMER’S RESPONSIBILITIES:
Consumers receiving PCS have certain responsibilities depending on the service delivery model they choose.

a. The consumer’s or legal representative's responsibilities under the consumer-delegated model include:
   i. Verifying that services have been rendered and signing accurate time sheets/logs for submission to the PCS agency for payroll;
   ii. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
   iii. Participating in the CNA process, at least annually, in the consumer’s primary place of residence;
   iv. Participating in the development and review of the IPoC;
   v. Maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer’s vehicle for support services that have been allocated to the consumer; and
   vi. Complying with all Medicaid rules, regulations, and PC service requirements; failure to comply may result in discontinuation of PCS.

b. The consumer’s or legal representative’s responsibilities under the consumer-directed model include:
   i. Interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:
      a) Verifying that the attendant possesses a current and valid state driver’s license if there are any driving-related activities listed on the IPoC; a copy of the current driver’s license must be maintained in the attendant’s personnel file at all times; if no driving-related activities are listed on the IPoC, a copy of a valid state ID is kept in the attendant’s personnel file at all times;
      b) Verifying that the attendant has proof of current liability vehicle insurance if the consumer is to be transported in the attendant’s vehicle at any time; a copy of the current proof of insurance must be maintained in the attendant’s personnel file at all times; and
c) Identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);

ii. Developing a list of attendants who can be contacted when an unforeseen event occurs that prevents the consumer’s regularly scheduled attendant from providing services; making arrangements with attendants to ensure coverage and notifying the agency when arrangements are changed;

iii. Verifying that services have been rendered by completing, dating, signing and submitting documentation to the agency for payroll; a consumer or his/her legal representative is responsible for ensuring the submission of accurate timesheets/logs; payment shall not be issued without appropriate documentation;

iv. Notifying the agency, within one business day, of the date of hire or the date of termination of his/her attendant and ensure that all relevant employment paperwork and other applicable paperwork is completed and submitted; this may include, but is not limited to: employment application, verification from the employee abuse registry, criminal history screening, doctor’s release to work, photo identification, proof of eligibility to work in the United States, copy of a state driver’s license and proof of insurance;

v. Notifying and submitting a report of an incident to the PCS agency within 24 hours of such incident, so that the PCS agency can submit an incident report on behalf of the consumer; the consumer or his/her legal representative is responsible for completing the incident report;

vi. Ensuring that the individual selected for hire has submitted a request for a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, within 20-calendar days of the individual beginning employment; the consumer must work with the selected agency to complete all paperwork required for submitting to the nationwide caregiver criminal history screening; the consumer may conditionally (temporarily) employ the individual contingent upon the receipt of written notice that the individual has submitted to a nationwide caregiver criminal history screening; a consumer may not continue employing an attendant who does not successfully pass a nationwide criminal history screening;

vii. Obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS he/she will be immediately terminated; A copy of the signed agreement must be provided to the PCS;

viii. Ensuring that if the attendant is the consumer’s legal representative and is the individual selected for hire, prior approval has been obtained from Medicaid
or its designee; any PCS provided by the consumer’s legal representative must be justified, in writing, by the PCS agency and consumer and submitted for approval to Medicaid or its designee prior to employment; the justification must demonstrate the lack of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure services were provided; documentation of written approval by Medicaid or its designee must be maintained in the consumer’s file; the consumer is responsible for immediately informing the agency if the consumer has appointed or obtained a legal representative any time during the plan year;

ix. Signing an agreement accepting responsibility for all aspects of care and training including mandatory training in cardiopulmonary resuscitation (CPR) and first aid for all attendants, competency testing, tuberculosis (TB) testing, hepatitis B immunizations, or waiving the provision of such training and accepting the consequences of such a waiver;

x. Verifying prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching the Consolidated Online Registry (COR) pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA, Section 27-7A-1 et seq.;

xi. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;

xii. Participating in the CNA process, at least annually, in the consumer’s primary place of residence;

xiii. Participating in the development and review of the IPoC;

xiv. Maintaining proof of current vehicle insurance (as mandated by the laws of the state of New Mexico) if the attendant will transport the consumer in the consumer’s vehicle for support services that have been allocated to the consumer;

xv. Complying with all Medicaid rules, regulations, and PCS requirements

c. Consumers may have a personal representative assist him/her to give instruction to the personal care attendant or to provide information to the MCO during assessments of the consumer's natural supports and service needs. A personal representative is not the same as a legal representative, but may be the same person. A personal representative must have the following qualifications: be at least 18 years of age, have a personal relationship with the consumer and understand the consumer's natural supports and service support needs, and know the consumer's daily schedule and routine (to include medications, medical and functional status, likes and dislikes, strengths and weaknesses). A personal representative does not make decisions for the consumer unless he/she is also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant,
unless he/she is also the legal representative and has obtained written approval from the MCO pursuant to these PCS regulations. A person's status as a personal representative must be properly documented with the PCS agency.

6. AGENCY PROVIDER REQUIREMENTS:
   a. Eligible PCS Agencies: PCS agencies electing to participate in providing PCS must obtain agency certification.
   b. PCS agency certification: A PCS agency providing either the consumer-directed, the consumer-delegated, or both models, must comply with the requirements of this section. PCS agencies must be certified by Medicaid or its designee. An agency listing, by county, is maintained by Medicaid or its designee. All certified PCS agencies are required to select a county in which to establish and maintain an official office for conducting of business with published phone number and hours of operation; the PCS agency must provide services in all areas of the county in which the main office is located. The PCS agency may elect to serve any county within 100 miles of the main office. The PCS agency may elect to establish branch office(s) within 100 miles of the main office. The PCS agency must provide PCS services to all areas of all selected counties.
      i. To be certified by Medicaid or its designee, agencies must meet the following conditions and submit for approval, a packet, to Medicaid’s fiscal agent or its designee, containing the following:
         a. A completed Medicaid provider participation agreement (PPA, also known as the MAD 335);
         b. Copies of successfully passed nationwide caregivers criminal history screenings on employees who meet the definition of “caregiver” and “care provider” pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act;
         c. A copy of a current and valid business license or documentation of non-profit status; if certified, a copy of the business license or documentation of non-profit status must be kept current and submitted annually;
         d. Proof of liability and workers’ compensation insurance (if certified, proof of liability and workers’ compensation insurance must be submitted annually to HSD and the MCO);
         e. A copy of written policies and procedures that address:
            i. Medicaid’s PCS provider rules and regulations;
            ii. Personnel policies; and
            iii. Office details that include but are not limited to:
               a. Contact information, mailing address, physical location if different from mailing address, and hours of operation for the main office and branch offices if any; designation of counties served by the office;
b. Meeting all Americans with Disabilities Act (ADA) requirements; and

c. If PCS agencies have branch offices, the branch office must have a qualified on-site administrator to handle day-to-day operations and receive direction and supervision from the main/central office;

f. Quality improvement to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:
   i. Service delivery;
   ii. Operational activities;
   iii. Critical incident and significant events management practices;
   iv. Quality improvement action plan; and
   v. Documentation of quality improvement activities;

g. Agency operations to furnish services as consumer-directed or consumer-delegated, or both;

h. A copy of a current and valid home health license, issued by the department of health, division of health improvement, licensing, and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of the requirements Paragraph (3) and Paragraph (5) (b and (d) above; if certified, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers’ compensation insurance;

i. Upon request, for approval to provide the consumer-delegated model of service, a copy of the agency’s written competency test for attendants approved by Medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:
   i. Communication skills;
   ii. Patient/member rights, including respect for cultural diversity;
   iii. Recording of information for patient/client records;
   iv. Nutrition and meal preparation;
   v. Housekeeping skills;
   vi. Care of the ill and disabled, including the special needs populations;
   vii. Emergency response (including CPR and first aid);
   viii. Universal precautions and basic infection control;
   ix. Home safety including oxygen and fire safety;
   x. Incident management and reporting; and
   xi. Confidentiality.
ii. After the packet is received, reviewed, and approved in writing by Medicaid or its designee, the agency will be contacted to complete the rest of the certification process; this will require the agency to:
   a. Attend a mandatory Medicaid or its designee’s provider training session prior to the delivery of PCS; and
   b. Possess a letter from Medicaid or its designee changing provider status from “pending” to “active”.

iii. An agency will not be certified as a personal care agency if:
   a. It is owned in full or in part by a professional authorized to complete the CNA or other similar assessment tool subsequently approved by Medicaid under PCS or the agency would have any other actual or potential conflict of interest;
   b. A conflict of interest is presumed between people who are related within the third degree of blood or consanguinity or when there is a financial relationship between:
      i. Persons who are related within the third degree of consanguinity (by blood) or affinity (by marriage) including a person’s spouse, children, parents (first degree by blood); siblings, half-siblings, grandchildren or grandparents (second degree by blood and uncles, aunts, nephews, nieces, great grandparents, and great grandchildren (third degree by blood); stepmother, stepfather, mother-in-law, father-in-law (first degree by marriage); stepbrother, stepsister, brothers-in-law, sisters-in-law, step grandchildren, grandparents (second degree by marriage); step uncles, step aunts, step nephews, step nieces, step great grandchildren, step great grandchildren (third degree by marriage);
      ii. Persons or entities with an ongoing financial relationship with each other including a personal care provider whose principals have a financial interest in an entity or financial relationship with a person who is authorized to complete a CNA or other similar assessment tool or authorized to carry out any of the MCO’s responsibilities; a financial relationship is presumed between spouses.

c. Approved PCS agency responsibilities: A personal care agency electing to provide PCS under either the consumer-directed model or the consumer-delegated model, or both, is responsible for:
   i. Furnishing services to Medicaid consumers that comply with all specified Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;
ii. Verifying every month that all consumers are eligible for full Medicaid coverage and PCS prior to furnishing services pursuant to Subsection A of 8.302.1.11 NMAC, provider responsibilities and requirements; PCS agencies must document the date and method of eligibility verification; possession of a Medicaid card does not guarantee a consumer’s financial eligibility because the card itself does not include financial eligibility, dates or other limitations on the consumer’s financial eligibility; PCS agencies must notify consumers who are not financially eligible that he/she cannot authorize employment for his/her attendant(s) until financial eligibility is resumed; PCS agencies and consumers cannot bill Medicaid or its designee for PCS services rendered to the consumer if he/she is not eligible for PCS services;

iii. Maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the Provider Participation Agreement (PPA);

iv. Maintaining records, as required by the PPA and as outlined in 8.302.1 NMAC, General Provider Policies, that are sufficient to fully disclose the extent and nature of the services furnished to the consumers;

v. Passing random and targeted audits, conducted by Medicaid or its designee, that ensure agencies are billing appropriately for services rendered; Medicaid or its designee will seek recoupment of funds from agencies when audits show inappropriate billing or inappropriate documentation for services;

vi. Providing either the consumer-directed or the consumer-delegated models, or both models;

vii. Furnishing to their consumers, upon request, information regarding each model; if the consumer chooses a model that an agency does not offer, the agency must refer the consumer to the MCO for a list of agencies that offer the chosen model; the MCO is required to explain each model in detail to each consumer annually;

viii. Ensuring that each consumer receiving PCS services has a current approved IPoC on file;

ix. Performing the necessary nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq. of the Caregivers Criminal History Screening Act, on all potential personal care attendants; nationwide caregiver criminal history screenings must be performed by an agency certified to conduct such checks; the agency, and the consumer, as applicable, ensures the paperwork is submitted within the first 20-calendar days of hire; consumers under the consumer-directed model or agencies under the consumer-delegated model may conditionally (temporarily) employ an attendant until such check has been returned from the certified agency; if the attendant does not then successfully pass the nationwide caregiver criminal history screening, the agency under consumer-
delegated or the consumer under consumer-directed may not continue employment of the attendant;

x. Producing reports or documentation as required by Medicaid or its designee;

xi. Verifying that consumers will not be receiving services through the following programs while they are receiving PCS: Medicaid home and community-based services (HCBS) through the Developmentally Disabled (DD) or Medically Fragile (MF) waivers; Medicaid certified nursing facility (NF), intermediate care facility/mentally retarded (ICF/MR), program of all-inclusive care for the elderly (PACE), or adult protective services (APS) attendant care program; recipients of community transition goods or services may receive PCO services; all individuals must meet the Medicaid and LOC eligibility requirements to receive PCS; the MCO must conduct an assessment or evaluation to determine if the transfer is appropriate and if PCS would be able to meet the needs of that individual; if an agency is authorized to provide services by the MCO in error, the MCO will bear the cost of the error.

xii. Processing all claims for PCS in accordance with the billing specifications from the MCO; payment shall not be issued without appropriate documentation;

xiii. Making a referral to an appropriate social service, legal, or state agency, or the MCO for assistance, if the agency questions whether the consumer is able to direct his/her own care or is non-compliant with Medicaid rules and regulations;

xiv. Immediately reporting abuse, neglect or exploitation pursuant to NMSA 1978, Section 27-7-30 and in accordance with the Adult Protective Services Act, by fax, within 24 hours of the incident being reported to the agency; reportable incidents may include but are not limited to abuse, neglect and exploitation as defined below:

a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish to a consumer;

b. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;

c. Exploitation is defined as the deliberate misplacement or wrongful, temporary or permanent use of a consumer’s belongings or money without the voluntary and informed consent of the consumer;

xv. Submitting written incident reports to Medicaid or its designee, and the MCO, on behalf of the consumer, within 24 hours of the incident being reported to the PCS agency; the PCS agency must provide the consumer with an appropriate form for completion; reportable incidents may include, but are not limited to:
a. Death of the consumer:
   1) Unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause;
   2) Natural/expected death is defined as any death of an individual caused by a long-term illness, a diagnosed chronic medical condition, or other natural/expected conditions resulting in death;

b. Other reportable incidents:
   1) Environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;
   2) Law enforcement intervention is defined as the arrest or detention of a person by a law enforcement agency, involvement of law enforcement in an incident or event, or placement of a person in a correctional facility;
   3) Emergency services refers to admission to a hospital or psychiatric facility or the provision of emergency services that results in medical care that is not anticipated for this consumer and that would not routinely be provided by a primary care provider;
   4) Any reports made to Adult Protective Services (APS);

xvi. Informing the consumer and his/her attendant of the responsibilities of the agency;

xvii. Develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;

xviii. Provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

xix. Identifying a consumer with an improved or declining health condition or whose needs have changed (i.e. more or less natural supports) and believe the consumer is in need of more or fewer services should send written notification to the MCO for an LOC determination and additional assessment of need of services; and

xx. Maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable.

d. For agencies providing PCS under the consumer-directed model, the responsibilities include:
   i. Providing services through an agency with choice model or as a fiscal employer agent, and complying with all applicable state and federal employment laws as applicable to the provision of such services;
   a. Agency with choice, in which the agency is the legal employer of the personal care attendant and the consumer is the managing employer and the agency maintains at least quarterly in-person contact with the consumer, or
b. Fiscal employer agent (FEA) in which the consumer is the legal employer of record and the managing employer; and the agency maintains at least quarterly in person contact with the consumer;

ii. Obtaining from the consumer or his/her legal representative a signed agreement in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS he/she will be immediately terminated; the agency must maintain a copy of the signed agreement in the attendant’s personnel file, for the consumer;

iii. Obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training, including mandatory training in CPR and first aid for all attendants, competency testing, TB testing, hepatitis B immunizations, or a waiver of providing such training, and accepting the consequences thereof; supervisory visits are not included in the consumer-directed option; a copy of the signed agreement must be maintained in the consumer’s file;

iv. Verifying, if the consumer has selected the consumer’s legal representative as the attendant, that the consumer has obtained prior approval from Medicaid or its designee; any personal care services provided by the consumer’s legal representative must be justified, in writing, by the agency and consumer, and submitted for approval to the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area, and indicate how timesheets will be verified to ensure that services were provided; documentation of written approval by the MCO must be maintained in the consumer’s file; the agency must inform the consumer that if the consumer selects a legal representative during the plan year, the consumer must notify the agency immediately, and the agency must ensure appropriate documentation is maintained in the consumer’s file;

v. Establishing and explaining to the consumer necessary payroll documentation for reimbursement of PCS;

vi. Performing payroll activities for the attendants, such as, but not limited to, state and federal income tax and social security withholding and making payroll liability payments;

vii. Arranging for unemployment coverage and workers’ compensation insurance;

viii. Informing the consumer of available resources for necessary training, if requested by the consumer, in the following areas: hiring, recruiting, training, supervision of attendants, advertising, and interviewing techniques;
ix. Making a referral to an appropriate social service agency, legal agency(s) or Medicaid designee for assistance, if the agency questions the ability of the consumer to direct his/her own care; and

x. Maintaining a consumer file, and an attendant personnel file for the consumer, for a minimum of six years.

e. For agencies providing PCS under the consumer-delegated model, the responsibilities include, but are not limited to the following:

i. Employing, terminating and scheduling qualified attendants;

ii. Conducting or arranging for training of all attendants for a minimum of 12 hours annually; initial training must be completed within the first three months of employment and must include:
   a. An overview of PCS;
   b. Living with a disability or chronic illness in the community;
   c. CPR and first aid training; and
   d. A written competency test with a minimum passing score of at least 80 percent; expenses for all training are to be incurred by the agency; other training may take place throughout the year as determined by the agency; the agency must maintain in the attendant’s file: copies of all training certifications; CPR and first aid certifications must be current;

e. Documentation of all training must include at least: name of trainee, title of the training, source, number of hours, and date of training;

e. Documentation of competency testing must include at least the following: name of individual being evaluated, date and method used to determine competency, and a copy of the attendant’s graded competency test indicating a passing score of at least 80 percent; special accommodations must be made for attendants who are not able to read or write, or who speak, read, or write only language(s) other than English;

iii. Developing and maintaining a procedure to ensure trained, qualified attendants are available as backup for regularly scheduled attendants, and for emergency situations; complete instructions regarding the consumer’s care and a list of attendant responsibilities must be available in each consumer’s home;

iv. Informing the attendant of the risks of hepatitis B infection per current department of health (DOH) or the center for disease control and prevention (CDC) recommendation, and offering hepatitis B immunization at the time of employment at no cost to the attendant; attendants are not considered to be at risk for hepatitis B since only non-medical services are performed, therefore attendants may refuse the vaccine; documentation of the immunization, prior immunization, or refusal of immunization must be in the attendant’s personnel file;
v. Obtaining a copy of the attendant’s current and valid state driver’s license or other current and valid state photo id, if the consumer is to be transported by the attendant; obtaining a copy of the attendant’s current and valid driver’s license and current motor vehicle insurance policy; maintaining copies of these documents in the attendant’s personnel file;

vi. Complying with federal and state labor laws;

vii. Preparing all documentation necessary for payroll;

viii. Complying with Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;

ix. Maintaining records sufficient to fully disclose the extent, duration, and nature of services furnished to the consumers as outlined in 8.302.1 NMAC, General Provider Policies;

a. The PCS agency may elect to keep a log/check list, in addition to the timesheet, in the consumer’s home, describing services provided on a daily basis; if a log/check list is maintained, the log must be compared with the weekly timesheet and copies of both the timesheet and the log/check list must be kept in the consumer’s file;

b. The PCS agency may elect to use an electronic system that attendants may use to check in and check out at the end of each period of service delivery; the system must produce records that can be audited to determine the time of services provided, the type of services provided, and verification by the consumer or the consumer’s legal representative; failure by a PCS agency to maintain a proper record for audit under this system will subject the PCS agency to recovery by Medicaid of any insufficiently documented claims;

x. Obtaining from the attendant a signed agreement, in which the attendant agrees that he/she will not provide PCS while under the influence of drugs or alcohol and acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS, he/she will be immediately terminated;

xi. Ensuring that if the consumer has elected the consumer’s legal representative as his/her attendant, the agency has obtained prior approval from Medicaid or its designee; all PCS provided by the consumer’s legal representative must be justified in writing by the agency and consumer and submitted for approval to the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area and include a plan for oversight by the agency to assure service delivery; documentation of approval by the MCO must be maintained in the consumer’s file; the agency must inform the consumer that if the consumer is appointed or selects a legal representative any time during the plan year, they must notify the agency immediately;
xii. Establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCS;

xiii. Performing payroll activities for the attendants;

xiv. Providing workers’ compensation insurance for attendants;

xv. Conducting face-to-face supervisory visits in the consumer’s residence at least monthly (12 per service plan year); each visit must be documented in the consumer’s file indicating:
   a. Date of visit;
   b. Time visiting to include length of visit;
   c. Name and title of person conducting supervisory visit;
   d. Individuals present during visit;
   e. Review of IPoC;
   f. Identification of health and safety issues and quality of care provided by attendant, and
   g. Signature of consumer or consumer's legal representative;

xvi. Maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;

xvii. Following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB; and

xviii. Verifying initially prior to employment, and annually thereafter, that attendants are not on the employee abuse registry by researching COR pursuant to 8.11.6 NMAC and in accordance with the Employee Abuse Registry Act, NMSA 1978, Section 27-7A-1 et seq.

f. Personal Care Attendant Responsibilities: Personal care attendants providing PCS for consumers electing either consumer-directed or consumer delegated must comply with the following responsibilities and requirements. They include:
   i. Being hired by the consumer (consumer-directed model) or the PCS agency (consumer-delegated model);
   ii. Not being the spouse of a consumer, pursuant to 42 CFR Section 440.167 and CMS state Medicaid manual section 4480-D;
   iii. Providing the consumer (consumer-directed), or the PCS agency (consumer-delegated), with proof of and copies of their current valid state driver’s license or current valid state photo ID, and if the attendant will be transporting the consumer, current valid driver’s license and current motor vehicle insurance policy;
   iv. Being 18 years of age or older;
   v. Ensuring that if the attendant is the consumer’s legal representative, and is the selected individual for hire, prior approval has been obtained from the MCO; any personal care services provided by the consumer’s legal representative must be justified, in writing, by the PCS agency, and
consumer, having been submitted for written approval to the MCO prior to employment; the justification must demonstrate the unavailability of other qualified attendants in the applicable area and indicate how timesheets will be verified to ensure that services were provided; documentation of approval by the MCO must be maintained in the consumer’s file; and submit appropriate documentation of time worked and services performed ensuring that he/she has signed his/her time sheet/log/check list verifying the services provided to the consumer;

vi. Successfully passing a nationwide caregiver criminal history screening, pursuant to 7.1.9 NMAC and in accordance with NMSA 1978, Section 29-17-2 et seq., of the Caregivers Criminal History Screening Act, performed by an agency certified to conduct such checks; attendants are required to submit to a criminal history screening within the first 20-calendar days of hire; an attendant may be conditionally hired by the agency contingent upon the receipt of written notice from the certified agency of the results of the nationwide criminal history screening; attendants who do not successfully pass a nationwide criminal history screening are not eligible for further PCS employment;

vii. Ensuring while employed as an attendant he/she will not be under the influence of drugs or alcohol while performing PCS; the attendant must complete and sign an agreement with the agency or consumer in which the attendant acknowledges that if he/she is under the influence of drugs or alcohol while providing PCS he/she will be immediately terminated;

viii. May not be the consumer's representative, unless he/she is also the legal representative;

ix. If the attendant is a member of the consumer’s family, he/she may not be paid for services that would have otherwise been provided to the consumer; if the attendant is a member of the consumer’s household, he/she may not be paid for household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer’s room, linens, clothing, and special diets);

x. An attendant may not act as the consumer’s legal representative, in matters regarding medical treatment, financial or budgetary decision making, unless the attendant has documentation authorizing the attendant to act in a legal capacity on behalf of the consumer;

xi. Following current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB, and

xii. For consumer-delegated care only, completing 12-hours of training yearly; the attendant must obtain certification of CPR and first aid training within
the first three months of employment, and the attendant must maintain
certification throughout the entire duration of providing PCS; additional
training will be based on the consumer’s needs as listed in the IPoC;
attendants are not required to be reimbursed for training time and must
successfully pass a written personal care attendant competency test with at
least 80 percent correct within the first three months of employment.

g. Coverage Criteria: PCS have been established to assist individuals 21 years of
age or older who are eligible for full Medicaid benefits and meet the NF LOC
criteria. PCS are defined as those tasks necessary to avoid institutionalization and
maintain the consumer’s functional level and independence. PCS are for
consumers who meet NF LOC because of disability or functional limitation and
need assistance with certain ADLs and IADLs. PCS are allocated for a
reasonable accommodation of tasks to be performed by a personal care attendant,
but do not provide 24-hours per day services. A CNA is conducted pursuant to
this policy, assessments for services, to determine the amount and type of services
needed to supplement the services a consumer is already receiving including those
services provided by natural supports. PCS are not provided 24 hours a day and
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.

i. PCS are usually furnished in the consumer’s residence, except as otherwise
indicated, and during the hours specified in the consumer’s IPoC. Services
may be furnished outside the residence only when appropriate and necessary
and when not available through other existing benefits and programs, such as
home health or other state plan or long-term care services. If a consumer is
receiving hospice care, is a resident in an assisted living facility, shelter
home, or room and board facility, the MCO will perform a CNA and ensure
that the PCS do not duplicate the services that are already being provided. If
ADL or IADL services are part of the hospice or assisted living facility,
shelter home, or room and board facility, as indicated by the contract or
admission agreement signed by the consumer, PCS cannot duplicate those
services. Regulations for assisted living facilities may be found at 7.8.2
NMAC, Assisted Living Facilities for Adults.

ii. PCS are not furnished to an individual who is an inpatient or resident of a
hospital, NF, ICF/MR, mental health facility, correctional facility, other
institutional settings, except for recipients of community transition goods or
services.

iii. All consumers, regardless of living arrangements, will be assessed for natural
supports. PCS are not intended to replace natural supports. Service hours
will be allocated, as appropriate, to supplement the natural supports available
to a consumer. Consumers that reside with other adult household members,
that are not receiving PCS or are not disabled, will be presumed to have household services in the common/shared areas provided by the other adult residents, whether or not the adult residents are the selected personal care attendant. Personal care attendants that live with the consumer will not be paid to deliver household services, support services (shopping and errands), or meal preparation that are routinely provided as part of the household division of chores, unless those services are specific to the consumer (i.e., cleaning consumer’s room, linens, clothing, and special diets). If a consumer’s living situation changes:

a. Such that there is no longer a shared living space with another consumer, he/she will be re-assessed for services that were allocated between multiple consumers in a shared household; or

b. Such that he/she begins sharing a living space with another consumer(s), all consumers in the new shared living space will be re-assessed to determine the allocation of services shared by all consumers residing in the household.

h. Covered Services: PCS are provided as described in 8.308.12.13 NMAC. PCS will not include those services for tasks the individual does not need or is already receiving from other sources including tasks provided by natural supports. PCS must be related to the individual’s functional level to perform ADLs and IADLs as indicated in the CNA conducted pursuant to this policy, assessments for services, mobility assistance, either physical assistance or verbal prompting and cueing, may be provided during the administration of any PCS task by the attendant. Mobility assistance includes assistance with ambulation, transferring, or repositioning, which is defined as moving around inside or outside the residence or consumer’s living area with or without assistive device(s) such as walkers, canes, and wheelchairs, or changing position to prevent skin breakdown.

i. Certain PCS are provided only when the consumer has the ability to self-administer. Ability to self-administer is defined as the ability to identify and communicate medication name, dosage, frequency and reason for the medication. A consumer who does not meet this definition of ability to self-administer is not eligible for these services.

ii. When two or more consumers living in the same residence, including assisted living facilities, shelter homes, and other similar living arrangements, are receiving PCS, they will be assessed both individually and jointly to determine services that are shared. Consumers sharing living space will be assessed for services identified in Paragraphs (5) and (7) of Subsection I of 8.308.12.13 NMAC: assess each consumer individually to determine if the consumer requires unique assistance with the service; and jointly with other household members to determine shared living space and common needs of
the household; services will be allocated based on common needs, not based on individual needs, unless as assessed by the MCO, an individual need for the service(s) is indicated; common needs may include meals that can be prepared for several individuals; shopping/errands that can be completed at the same time; laundry that can be completed for more than one individual at the same time; dusting and vacuuming of shared living spaces; these PCS are based on the assessment of combined needs in the household without replacing natural and unpaid supports identified during the assessment.

iii. Description of PCS refer to 8.308.12.13 NMAC.

i. Assessments for Services: After the consumer is determined medically eligible for PCS, the MCO determines, allocates, and authorizes PCS based on a functional assessment, which is part of the CNA process. Although a consumer’s assessment for the amount and types of services may vary, PCS are not provided 24 hours a day. An individual’s PCS are directly related to their functional level to perform ADLs and IADLs as indicated by the CNA. The CNA is performed when a consumer enters the program, at least annually or at the discretion of the MCO.

i. The CNA determines the type of covered services needed by the consumer. The amount of time allocated to each type of covered service is determined by applying and recording the individual’s functional level to perform ADLs and IADLs. PCS are allocated for a reasonable accommodation of tasks to be performed by a personal care attendant. A CNA determines the amount and type of PCS needed to supplement and not duplicate the services a consumer is already receiving including those services provided by natural supports. In the event that the consumer’s functional needs exceed the average allocation of time allotted to perform a particular service task per the recommendation of a medical professional, the MCO may consider authorization of additional time based on the consumer’s verified medical and clinical need.

ii. The CNA is conducted by the MCO and discussed with the consumer in the consumer’s primary place of residence. It serves to document the current health condition and functional needs of the consumer. It is to include no duplication of services a consumer is already receiving, including those services provided by natural supports, and shall not be based on a prior assessment of the consumer’s health condition, functional needs, or existing services.

iii. The completed CNA is sent to the PCS agency by the MCO to allow the PCS agency to develop the IPoC.

iv. The CNA must be performed by the MCO upon a consumer’s initial approval for medical NF LOC eligibility to receive PCS and at least annually thereafter, based on their assigned care coordination level or at the MCO’s
discretion. The annual CNA is completed prior to the expiration of the current NF LOC period and determines the type and amount of services for the subsequent NF LOC period. The type and amount of PCS as determined by the CNA shall not be effective prior to the start of the applicable NF LOC period. An interim assessment may be conducted if:

a. There is a change in the consumer’s condition (either improved or declined);
b. There is a change in the consumer’s natural supports or living conditions;
c. Upon the consumer’s request;
d. The care coordination level requires an updated CNA;
e. The full amount of services has not been utilized within the last two months;
f. Upon a referral from a PCS agency regarding the consumer’s need for assessment CNA; or
g. At the MCO’s discretion.

v. The MCO must explain each service delivery model at least annually to consumers enrolled in Agency Based Community Benefits (ABCB).

vi. The MCO will issue a prior authorization (PA) to the PCS agency. A PCS authorization cannot extend beyond the LOC period and must be provided to the PCS agency prior to the PA effective date and may not be applied retroactively.

vii. A PCS consumer who disagrees with the authorized number of hours may utilize the MCO grievance and appeal process when enrolled in managed care. The consumer must exhaust the appeals process with the MCO before a fair hearing can be requested pursuant to 8.352.2 NMAC, Recipient Hearings. Upon notification of the resolution of the appeal or grievance, a member may request a fair hearing with the State. The MCO may schedule a pre-hearing conference with the consumer to explain how the PCS regulations were applied to the authorized service time, and attempt to resolve issues prior to the fair hearing.

viii. Continuation of benefits: A member may continue PCS benefits while an MCO grievance and appeal or state fair hearing decision is pending, pursuant to 8.352.2 NMAC, Recipient Hearings, if the member requests continuation of benefits within 13 calendar days of the date of the notice of action.

ix. The member shall be responsible for repayment of the cost of the services furnished while the MCO grievance and appeal process or the state’s fair hearing process was pending, to the extent that the services were furnished solely because of this requirement to provide continuation of benefits during
the MCO grievance and appeal or state fair hearing process. The MCO may recover these costs from the member, not the provider.

j. Individual Plan of Care (IPOC): An IPOC is developed, and PCS are identified, with the appropriate assessment (CNA) for allocating PCS. The PCS agency develops an IPOC using an MCO authorization. The finalized IPOC must contain a seven-day schedule including the identification and documentation of natural support days not authorized for PCS, and authorized PCS attendant task-days and tasks to be performed by the PCS attendant. Only those services identified as IADLs, household support services, or certain ADL PCS such as meal preparation may be moved to another day, using the IPOC. The PCS agency must document more, and less, service time on the IPOC for specific day(s) during the week so long as the consumer has his/her daily needs met and the total weekly hours do not exceed the weekly task total. Consumers receiving services only a certain number of days of the week may not be allocated time for ADLs on days in which an attendant does not provide services (i.e., time will not be allocated for ADLs for seven calendar days if a consumer receives services only four calendar days during the week). Any tasks not performed by the attendant cannot be “banked” or otherwise saved for a later date.

i. The PCS agency must:
   a. Develop the IPOC with a specific description of the attendant’s responsibilities, including tasks to be performed by the attendant and any special instructions related to maintaining the health and safety of the consumer;
   b. Ensure the consumer has participated in the development of the plan and that the IPOC is reviewed and signed by the consumer or the consumer’s legal representative; a consumers’ signature on the IPOC indicates that the consumer understands what services have been identified and that services will be provided on a weekly basis for a maximum of one year; if a consumer is unable to sign the IPOC and the consumer does not have a legal representative, a thumbprint or personal mark (i.e., an “X”) will suffice; if signed by a legal representative, Medicaid or its designee and the agency must have documentation in the consumer’s file verifying the individual is the consumer’s legal representative;
   c. Maintain an approved IPOC for PCS for a maximum of one year (12 consecutive months), a new IPOC must be developed at least annually, to ensure the consumer’s current needs are being met; a consumer’s previous year IPOC is not used or considered in developing a new IPOC and allocating services; a new IPOC must be developed independently at least every year based on the consumer’s current
medical condition; the tasks and number of hours in the IPoC must match the authorized tasks and number of hours on the authorization;

d. Submit the proposed IPoC to the MCO for final review and approval;

e. Provide the consumer with a copy of their approved IPoC;

f. Obtain an approved task list and/or CNA;

g. Obtain written verification that the consumer, or the consumer’s legal representative, understands that if the consumer does not utilize services, for two months, the full amount of allocated services on the IPoC, that these circumstances will be documented in the consumer’s file; and

h. Submit a personal care transfer/closure form (MAD 062 or other approved transfer/closure form) to the MCO for a consumer who has passed away or who has not received services for 90-consecutive days.

k. PCS are to be delivered only in the state of New Mexico. However, consumers who require PCS out of the state, for medically necessary reasons, may request and exception, and must obtain written approval from the MCO for out-of-state delivery of service prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out-of-state services:

i. A letter from the consumer or the consumer’s legal representative requesting an out-of-state exception and reasons for the request; the letter must include:

   a. The consumer’s name and social security number;
   
   b. How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
   
   c. Date the consumer will be leaving the state, including the date of the medical procedure or other medical event, the anticipated date of return; and
   
   d. Where the consumer will be housed after the medical procedure.

ii. A letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and

iii. A copy of the consumer’s approved IPoC and a proposed adjusted revision of services to be provided during the time the consumer is out-of-state; support services and household services will not be approved unless justified; if the consumer has been approved for services under self-administered medications, a statement from the physician, physician assistant, nurse practitioner, or clinical nurse specialist must be included indicating the consumer will continue to have the ability to self-administer for the duration of time he/she is out-of-state.

l. Utilization Review (UR): All PCS require prior LOC approval by the MCO; therefore, retroactive services are not authorized. All PCS are subject to
utilization review for medical necessity and program compliance. The MCO will perform utilization review for medical necessity. The MCO makes final authorization of PCS using:

i. The HSD-approved LOC criteria; and

ii. The CNA.

m. Transfer Process for PCS: A consumer wishing to transfer services to another Medicaid approved PCS agency may request a personal care transfer/closure form (MAD 062 or other approved transfer/closure form). Transfers within the plan year may be requested by the consumer, but must be approved by the MCO prior to the agency providing PCS to the consumer. All requests for change of service model (from/to directed/delegated) must be approved by the MCO prior to the receiving agency providing services to the consumer. Transfers may only be initiated by the consumer or his/her legal representative and may not therefore be requested by the attendant. The transfer process is determined by the MCO and should be initiated by the consumer through the consumer’s assigned care coordinator. The consumer must give the reason for the requested transfer.

i. A transfer requested by a consumer may be denied by the MCO for the following reasons:

   a. The consumer is requesting more hours/services;

   b. The consumer’s attendant or family member is requesting the transfer;

   c. The consumer has requested three or more transfers within a six-month period;

   d. The consumer wants his/her legal guardian, spouse or attorney-in-fact to be his/her attendant;

   e. The consumer wants an individual to be his/her attendant who has not successfully passed a nationwide criminal history screening;

   f. The consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;

   g. The attendant does not want to complete the mandated trainings under the consumer-delegated model;

   h. The consumer does not wish to comply with the Medicaid or PCS regulations and procedures; and

   i. There is reason to believe that solicitation has occurred as defined in this policy in the, Solicitation/Advertising section in this policy.

ii. The MCO will notify the consumer and both the originating agency and the receiving agency of its decision within 15 working-days after receiving the request. The consumer may verify that his/her request was received by the MCO.
iii. A consumer who does not agree with the MCO’s decision shall utilize the MCO grievance and appeal process. Upon receiving notification of the resolution of the appeal or grievance by the MCO, a consumer may request a fair hearing pursuant to 8.352.2 NMAC, Recipient Hearings. The originating agency is responsible for the continuance of PCS while the hearing is pending, if requested timely by the consumer and approved by the MCO, as identified in the assessments for services section of this policy.

iv. The following is the process for submitting a transfer request:
   a. The consumer must inform the MCO of the desire to transfer to another PCS agency; the MCO approves or denies the transfer request; if approved, the MCO works with both the agency from which he/she is currently receiving services (originating agency) and the agency to which he/she would like to transfer (receiving agency) to complete the transfer.
   b. Originating agencies are responsible for continuing service provision until the transfer is complete.
   c. Both the originating and receiving PCS agencies are responsible for following transfer procedures.
   d. After the MCO verifies the consumer’s request, the MCO will process the transfer request within 15 business days after receiving the transfer request.
   e. The MCO will issue a new prior authorization number and task information to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer with new dates of service and units remaining for the remainder of the IPoC year; the MCO will notify the consumer as well as the originating and receiving PCS agencies.

n. Consumer Discharge: A consumer may be discharged from a PCS agency or may be discharged by HSD from receiving any PCS.

o. PCS Agency Discharge: The PCS agency may discharge a consumer for a justifiable reason, as explained below. Prior to initiating discharge, the PCS agency must send a notice to the MCO for approval. Once approved by the MCO, the PCS agency may initiate the discharge process with a 30-day written notice to the consumer. The notice must include the consumer’s right to request an appeal with the MCO and that he/she must exhaust the grievance and appeal process with the MCO before a fair hearing can be filed with HSD pursuant to 8.352.2 NMAC, Recipient Hearings. The notice must include the justifiable reason for the agency’s decision to discharge.

i. A justifiable reason for discharge may include:
a. Staffing problems (i.e., excessive request for change in attendants, such as three or more during within 30 calendar days);
b. A consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e. sexually) language, sexual harassment, excessive use of force, use of verbal threats or physical threats, or intimidating behavior; the agency or attendant must have documentation demonstrating the pattern of abuse; the agency may also discharge a consumer if the life or safety of an attendant or agency’s staff member is believed is in immediate danger;
c. A consumer or family member demonstrates a pattern of uncooperative behavior including not complying with agency or Medicaid regulations; not allowing the PCS agency to enter the home to provide services; and continued requests to provide services not approved on the IPoC;
d. Illegal use of narcotics or alcohol abuse;
e. Fraudulent submission of timesheets; or
f. Living conditions or environment that may pose a health or safety risk or cause harm to the personal care attendant, employee of an agency, MCO, or other Medicaid designee.

ii. The MCO must provide the consumer with a current list of Medicaid-approved personal care agencies that service the county in which the consumer resides. The PCS agency must assist the consumer in the transfer process, cooperate with the MCO, and continue services throughout the transfer process. If the consumer does not select another PCS agency within the 30-day time frame, the current PCS agency must inform the MCO’s care coordinator and the consumer that a lapse in services will occur until the consumer selects an agency.

iii. A consumer has a right to appeal the PCS agency’s decision to suspend services. The consumer must exhaust the MCO grievance and appeal process prior to requesting a fair hearing with HSD as outlined in 8.352.2 NMAC, Recipient Hearings.

p. Discharge by the state: Medicaid or its designee reserves the right to discontinue the consumer’s receipt of PCS due to the consumer’s non-compliance with Medicaid regulations and/or PCS requirements. The discontinuation of PCS does not affect the consumer’s Medicaid eligibility. The consumer may be discharged for a justifiable reason by means of a 30-day written notice to the consumer. The notice will include the duration of discharge, which may be permanent, the consumer’s right to request a fair hearing, pursuant to 8.352.2 NMAC, Recipient
Hearings, and the justifiable reason for the discharge. A justifiable reason for discharge may include:

i. Staffing problems (i.e., unjustified excessive requests for change in attendants, such as three or more during a 30-day period), excessive requests for transfers to other agencies or excessive agency discharges;

ii. A consumer who demonstrates a pattern of verbal or physical abuse toward attendants, agency personnel, or state staff or contractors, including use of vulgar or explicit sexual language, verbal or sexual harassment, excessive use of force, demonstrates intimidating behavior, verbal or physical threats toward attendants, agency personnel, or state staff or contractors;

iii. A consumer or family member who demonstrates a pattern of uncooperative behavior including, noncompliance with agency, Medicaid program requirements or regulations or procedures;

iv. Illegal use of narcotics, or alcohol abuse;

v. Fraudulent submission of timesheets; or

vi. Unsafe or unhealthy living conditions or environment.

q. PCS agencies and the MCO are responsible for documenting and reporting any incidents involving a consumer to Medicaid or its designee.

7. REIMBURSEMENT:

A Medicaid-approved PCS agency will process billings in accordance with the following:

a. Agencies must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See 8.302.2 NMAC, Billing for Medicaid Services. Once enrolled, agencies receive instructions on documentation, billing, and claims processing. Claims must be filed per the billing instructions in the Medicaid manual for fee-for-service (FFS), or instructions from the MCO. PCS agencies must use ICD-9-CM diagnosis codes when billing for Medicaid services.

b. Reimbursement for PCS is made at the lesser of the following:

1. The provider’s billed charge; or

2. The Medicaid fee schedule for the specific service or procedure.

The agency’s billed charge must be the usual and customary charge for services. “Usual and customary charge” refers to the amount an individual provider charges the general public in the majority of cases for a specific service and level of service.

8. PCS PROVIDER VOLUNTARY DISENROLLMENT:

A Medicaid approved PCS agency may choose to discontinue provision of services by disenrollment. Once approved by Medicaid or its designee, the PCS agency may initiate
the disenrollment process to assist consumers to transfer to another Medicaid approved PCS agency. The PCS agency must continue to provide services until consumers have completed the transfer process and the agency has received approval from Medicaid or its designee to discontinue services. Prior to disenrollment, the PCS agency must send a notice to Medicaid or its designee for approval. The notice must include:

a. Consumer notification letter;
b. List of all the Medicaid approved personal care agencies serving the county in which the consumer resides; and
c. List of all consumers currently being served by the agency and the MCO in which they are enrolled.

9. SOLICITATION/ADVERTISING:
For the purposes of this section, solicitation shall be defined as any communication regarding PCS services from an agency’s employees, affiliated providers, agents or contractors to a Medicaid member who is not a current client that can reasonably be interpreted as intended to influence the recipient to become a client of that entity. Individualized personal solicitation of existing or potential consumers by an agency for their business is strictly prohibited.

a. Prohibited solicitation includes, but is not limited to, the following:
   i. Contacting a consumer who is receiving services through another PCS or any another Medicaid program;
   ii. Contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone and email solicitation;
   iii. Offering a consumer/attendant a finder fee, kick back, or bribe consisting of anything of value to the consumer to obtain transfers to its agency; see 8.351.2 NMAC, Sanctions and Remedies;
   iv. Directly or indirectly engaging in door-to-door, telephone, or other cold-call marketing activities by the entity’s employees, affiliated providers, agents or contractors;
   v. Making false promises;
   vi. Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
   vii. Misrepresenting itself as having affiliation with another entity; and
   viii. Distributing PCS-related marketing materials.

b. Penalties for engaging in solicitation prohibitions: Agencies found to be conducting such activity will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.

c. An agency wishing to advertise for PCS provision must first get prior written approval from Medicaid or its designee before conducting any such activity.
Advertising and community outreach materials means materials that are produced in any medium, on behalf of a PCS agency and can reasonably be interpreted as advertising to potential clients. Only approved advertising materials may be used to conduct any type of community outreach. Advertising or community outreach materials must not misrepresent the agency as having affiliation with another entity or use proprietary titles, such as “Medicaid PCS”. Any PCS agency conducting any such activity without prior written approval from Medicaid or its designee will be subject to sanctions and remedies as provided in 8.351.2 NMAC and applicable provisions of the PPA.

10. SANCTIONS AND REMEDIES:
Any agency or contractor that is not compliant with the applicable Medicaid regulations is subject to sanctions and remedies as provided in 8.351.2 NMAC.
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 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). Specific services may include the following:

1. SCOPE OF SERVICES
   a. Obtaining pertinent medical history.
   b. Observing and assessing the member’s condition.
   c. Administration of medications to include: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes.
   d. Providing wound care, suture removal and dressing changes.
   e. Monitoring feeding tubes (i.e. gastrostomy, naso-gastric, or jejunostomy including patency), including signs of possible infection
   f. Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal.
   g. Monitoring aspiration precautions.
   h. Monitoring administration of oxygen, ventilator management, and member’s response.
   i. Monitoring infection control methods.
   j. Monitoring seizure protocols.
   k. Collecting specimens (blood, urine, stool, or sputum) and obtaining cultures as ordered by the member’s primary physician.
1. Alerting the member’s physician to any change in health status.

m. Monitoring nutritional status of the member and reporting any changes to the physician and nutritionist if available.

n. Maintaining member intake and output flow sheets as ordered by the physician.

o. Performing physical assessments including monitoring of vital signs and the member’s medical condition as warranted.

p. Providing education and training to the member’s appropriate family member(s) and primary caregiver(s) regarding care needs and treatments etc. The goal for education and training is to encourage self-sufficiency in delivery of care by the family or primary caregiver.

q. Providing staff supervision of appropriate activities, procedures and treatment.

r. The Plan of Care/Treatment will be developed in collaboration with the member, and the MCO Care Coordinator. The plan will identify and address the member’s specific needs in accordance with the physician’s orders. Develop and implement the Plan of Care/Treatment (CMS form 485) on the basis of the member assessment and evaluation.

s. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.

t. Develop interventions to assist the member to achieve and promote health to meet the individual member’s needs.

u. Develop individualized service goals, identifying short-and long-term goals that are measurable and objective.

v. Document dates and types of treatments performed, as well as member’s response to treatment and progress toward all goals.

2. SERVICE REQUIREMENTS

a. The private duty nurse must perform a comprehensive assessment/evaluation for each member and coordinate with the MCO Care Coordinator to determine appropriate services annually at a minimum or at each visit.

b. Private Duty Nursing Services listed in the Care Plan are to be within the scope of the New Mexico Nurse Practice Act, are provided subsequent to obtaining a physician’s order, under the supervision of a Registered Nurse (RN). Physician’s orders will contain the following:

i. The task to be performed,

ii. How frequently the task is to be performed,

iii. The duration that the order is applicable,

iv. Any individualized instructions. Additionally a physician’s order will be obtained for the revision of any nursing service and annually with the Individual Service Plan renewal, if nursing services are to continue.

c. The Private Duty Nursing Supervisor will provide clinical supervision in the member’s home at a minimum of once each quarter.
d. Supervision of Private Duty Nursing Services must be documented in the member’s clinical record.

e. The Plan of Care/Treatment (Form CMS-485) will be provided to the MCO. Within 48 hours of any changes ordered by the physician, the provider agency will inform the MCO Care Coordinator of physician ordered changes and the agency’s ability or inability to provide Private Duty Nursing in accordance with the Care Plan. The provider agency will provide the MCO with a copy of revised orders.

f. Submitting initial and quarterly progress reports to the MCO. Copies of quarterly progress reports sent to the MCO will be maintained in the member file and will include an assessment of the member’s current status, health and safety issues and the progress goals as listed on the plan of care/treatment.

g. Reviewing and revising the nursing plan of care/treatment making appropriate treatment modifications as necessary and coordinate with the MCO Care Coordinator of the changes that may need to be identified and/or changed on the Care Plan.

h. Document complications that delay, interrupt, or extend the duration of the services in the member’s medical record as well as communication with the member’s physician.

i. Reviewing physician’s request for treatment. If appropriate, recommend revisions to the Care Plan to the MCO Care Coordinator by requesting a conference.

j. Providing member and/or caregiver education regarding services. Document the date and time this occurred in the member’s clinical file.

3. AGENCY/INDIVIDUAL PROVIDER REQUIREMENTS

a. Staffing Requirements.

i. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is considered a qualified private duty nurse when the following criteria are met.

ii. Must have current licensure as required by the state of New Mexico.

iii. Nursing experience preferably with disabled and elderly individuals. This includes settings such as home health, hospital, nursing home facility, or other types of clinics and institutions.

iv. Nursing services must be furnished through a licensed Home Health Agency, licensed Rural Health Clinic or certified federally Qualified Health Center.

v. Registered Nurses who supervise should have at least one year of supervisory experience. Supervision of licensed practical nurses must be provided by a registered nurse and shall be in accordance with the New Mexico Nursing Practice Act. The supervision of all personnel is the responsibility of the agency’s Administrator and Director.
vi. Be culturally sensitive to the needs and preferences of member’s and their households based upon language. Communicating in a language other than English may be required.

vii. Hepatitis B vaccine will be offered by the provider agency upon employment at no cost to the employee per the federal OSHA requirements. Record of prior Hepatitis B immunization, acceptance or denial by the employee will be maintained in the employee’s personnel record.

b. Administrative Requirements

i. Must comply with all applicable state and federal rules and regulations for licensed home health agencies and program standards determined by HSD/MAD including but not limited to Criminal Background Checks, OSHA training requirements, Incident Management System reporting, Labor Laws and etc.

ii. All services must be under the order of the member’s Primary Care Physician. The order will be obtained by an RN working for the agency that provides private duty nursing services, and will be shared with the MCO.

iii. Reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible for providing clinical documentation that identifies his or her role in all components of the provision of nursing services, including assessment information, care planning, intervention, communications, and evaluation. There must be justification in each member’s clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity and must be covered by the ABCB. Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for private duty nursing for adults’ services will be based on the negotiated rate with the MCOs. Providers have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

a. Payment for private duty nursing services through the MCO is considered payment in full.

b. Private duty nursing services must abide by all federal, state, HSD, policies and procedures regarding billable and non-billable items.

c. Billable hours are as follows:
i. Face-to-face activities that are described above in the Scope of Service for Private Duty Nursing.

ii. Attendance and/or telephone conference call to participant in interdisciplinary team meetings.

iii. Development of the plan of care/treatment, not to exceed four (4) hours annually.

iv. Reimbursement is on a unit rate per hour and rounded to the nearest quarter.

v. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

d. HSD/MAD does not consider the following to be professional private duty nursing services and will not authorize payment for the following non-billable activities:

i. Performing specific errands for the individual and/or family that are not program specific.

ii. Friendly visiting.

iii. Financial brokerage services, handling of member finances, or preparation of legal documents.

iv. Time spent on paperwork or travel that is administrative for the provider.

v. Transportation of members.

vi. Pick up and/or delivery of commodities.

vii. Other non-Medicaid reimbursable activities.

e. Private duty nursing services are provided with understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

f. Private duty nursing services ensure all insurance records are maintained correctly.

g. Reimbursement for private duty nursing services will be based on the current negotiated with the MCO the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

h. The ABCB does not provide 24 continuous hours of nursing services for any member except as a Private Duty Nursing Respite service provider. This does not preclude the use of other funding sources for nursing such as Medicare or private pay etc., to supplement ABCB Service nursing services for a member.
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). Respite services are limited to a maximum of 100 hours per Care Plan year. 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;

1. SCOPE OF SERVICES
   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.

2. SERVICE REQUIREMENTS
   a. Respite services are available to any member of any age.
   b. Respite services are determined by the MCO Care Coordinator and documented on the Care Plan.
   c. Respite services may be provided in the member’s home, in the respite provider’s home, and in the community.

3. AGENCY PROVIDER REQUIREMENTS
   a. The provider agency of Nursing Respite Services must meet all requirements, certifications and training standards set forth by the HSD/MAD to provide Private Duty Nursing services, as described in the Private Duty Nursing service standards.
   b. Refer to the appropriate program standards for Private Duty Nursing services for additional information on certification requirements, supervision requirements, services, and program standards for the provision of Private Duty Nursing Respite Services.
c. Supervision of Nursing Respite Service employees must be documented by the Nursing respite supervisor. The supervisor must be a staff member of the nursing respite provider agency and provide in-service training to the personnel providing the care.

d. Supervision of Nursing Respite Services will be done at least quarterly. A Registered Nurse must supervise Private Duty Nursing Respite employees. The supervisory nurse must be on the staff or a MCO of the provider agency to supervise and provide in-service training to the personnel providing the care.

e. Nursing Respite service providers must maintain a current roster that is updated quarterly of Nurse Respite providers to provide services as requested by the member or family.

f. Nursing Respite service providers must immediately notify the MCO Care Coordinator if there is a change in the member’s condition, if the member refuses care or if the agency is unable to comply with the care delivery as agreed upon in the Care Plan.

4. AUTHORIZATION OF NURSING RESPITE CARE SERVICES

a. Scheduling of hours for use of Nursing Respite Services will be the responsibility of the Nursing Respite Service Provider and the member.

b. Nursing Respite services provided by the Private Duty Nursing provider require a physician’s order that includes the scope and duration of service(s). A new physician’s order will be obtained when there is a revision in the service, and/or on an annual basis with the Care Plan renewal. The order must be obtained by the agency providing PDN and shared with the MCO.

c. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement.

d. The provider of Nursing Respite Services must maintain a cumulative record of utilization of respite care, to include time used.

e. The member cannot schedule his or her own respite with the nursing respite staff.

f. The member may receive a maximum of 100 hours annually per Care Plan year provided there is a primary caregiver.

5. REIMBURSEMENT

a. Reimbursement is on an hourly unit rate and is accrued to the nearest quarter of an hour. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

b. Reimbursement for Nursing Respite services will be based on the current negotiated with the MCO the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If
the provider identifies an error they will contact the MCO immediately to have the error corrected.
RESPITE SERVICES

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. Respite services may be provided in the member’s home, in the respite provider’s home and in the community. Respite services are limited to a maximum of 100 hours per Care Plan year. Respite services must not be provided by a member of the member’s household or by any relative approved as the employed caregiver. Respite Services are provided to ABCB members on an episodic basis that enables members to accomplish tasks that they would normally do for themselves if they did not have a disability. Respite services assist the members to maintain the home (or living area occupied by the participant) in a clean and safe environment and assist the member in activities of daily living (ADL). Respite services are provided pursuant to the Care Plan, developed and authorized by the recipient of service and the MCO Care Coordinator. Specific services may include the following:

1. SCOPE OF SERVICES
   a. Household Activities – The following household activities are considered necessary to maintain a clean and safe environment and to support the member’s living in their home. These activities are limited to maintenance of the member’s individual living area (i.e. kitchen, living room, bedroom, and bathroom). For example, the respite staff would not clean the entire home if the member only occupies three (3) rooms in a house of (6) rooms. In this case, the caregiver would clean the three rooms only. The respite services will assist the member in performing these activities independently or semi-independently when appropriate. These duties are performed as indicated in the Care Plan:

   i. Sweeping, mopping or vacuuming of carpets, hardwood floors, or linoleum;
   ii. Dusting of furniture;
   iii. Changing of linens;
   iv. Doing laundry (member’s clothing and linens only);
   v. Cleaning bathrooms (tub and/or shower area, sink, and toilet); and/or
   vi. Cleaning of kitchen and dining area after preparation and serving meals by the respite staff for member, such as washing dishes, putting dishes away; cleaning counter tops, dining table where the member ate, and sweeping the floor, etc.

   b. Meal Preparation – A tentative schedule for preparation of meals will be identified in the Care Plan as determined by the assessment. The respite staff will
assist the member in independent or semi-independent meal preparation, including dietary restrictions per physician order.

c. Personal Care – The Care Plan may include the following tasks to be performed by the respite service:

i. Bathing – Giving a Sponge bath/Bed bath/Tub Bath/Shower, including transfer in/out;

ii. Dressing – Putting on, fastening, removing clothing; including prosthesis;

iii. Grooming – Shampooing, combing or brushing hair, applying make-up, trimming beard or mustache, braiding hair, shaving under arms or legs as requested by the member;

iv. Oral care – Brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash). Members whose swallowing reflex is not intact, are an exception and may require specialized oral care beyond the scope of this service as identified by a physician’s order;

v. Nail care – Cleaning or filing to trim and or do cuticle care. Members with diabetes are an exception and may require specialized nail care beyond the scope of this service as identified by a physician’s order;

vi. Perineal Care – Cleansing of the perineal area and changing of sanitary napkins;

vii. Toileting – Transferring on/off toilet, bedside commode and/or bedpan; cleaning perinea area, changing adult briefs/pads, readjusting clothing;

viii. Bowel Care – Evacuation and ostomy care, including irrigations, changing and cleaning of bags, and ostomy site skin care. Members requiring the assistance of bowel care must be determined medically stable by his or her physician, and are able to communicate their bowel care verbally or in writing. A physician must prescribe a bowel program for the member. A registered nurse is required to provide whatever additional training the respite staff needs to ensure the respite staff is competent to implement the member’s bowel program. The respite staff must demonstrate competency to the nurse that he or she is able to properly implement the bowel program according to the physician’s order(s);

ix. Bladder Care – Elimination, catheter care, including the changing and cleaning of catheter bag. Members requiring the assistance of a bladder care must be determined medically stable by his or her physician, and are able to communicate their bladder care verbally or in writing. A physician must prescribe a bladder program for the member. A registered nurse is required to provide whatever additional training the homemaker staff needs to ensure the respite staff is competent to implement the member’s bladder program. The respite staff must demonstrate competency to the nurse that he or she is
able to properly implement the bladder program according to the physician’s order(s).

x. Mobility Assistance – Assistance in ambulation, transfer and toileting, Defined as follows:

xi. Ambulation – Moving around inside and/or outside the home or member’s living area with or without assistive device(s) such as walkers, canes and wheelchairs;

xii. Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or

xiii. Toileting – Transferring on or off toilet.

xiv. Skin Care – Observation of skin condition for maintaining good skin integrity and prevention of skin infection, irritation, ulceration or pressure sores.

xv. Assisting with Self-Administered Medication – Prompting and Reminding in accordance with the New Mexico Nursing Practice Act. Getting a glass of water or juice as requested if member is not able to do that for himself/herself, handing the member a daily medication box or medication bottle. For the nurse practice act, refer to the PDN service standards.

xvi. Eating – Assistance with eating as determined in the Care Plan. Individuals requiring tube feeding or J-tube feedings or who are at risk for aspiration are an exception and require specialized care as prescribed by physician.

xvii. Range of Motion Exercises as described in a Therapeutic Plan developed by therapists and taught to the caregiver and caregiver supervisor by a Physical Therapist or Occupational Therapist.

xviii. Support Services – Support services provide additional assistance to members in order to promote independence and enhance his or her ability to remain in a clean and safe environment. The following support services will be identified in the assessment of the Instrumental Activities of Daily Living and are provided as determined in the Care Plan:

xix. Shopping and/or completing errands for the member, with or without the member; and

xx. Accompanying or assisting with non-medical transportation.

2. AGENCY PROVIDER REQUIREMENTS

The respite staff must possess a current New Mexico driver’s license and a Motor vehicle insurance policy if the member is to be transported by the respite staff. Release of Liability Forms must be completed and on file in the member and/or employee’s file. Respite provider agencies are not required to provide transportation services. The MCO Care Coordinator assess the member’s formal and informal support system and determine if other individuals and/or other Medicaid agencies can provide assistance with shopping and transportation services.
a. Service Requirements

i. Respite services are available to any member of any age.

ii. Respite services are determined by MCO Care Coordinator and documented on the Care Plan.

iii. Respite services may be provided in the member’s home, in the respite provider’s home, and in the community.

b. Administrative Requirements:

i. Respite agencies may be licensed by the Department of Health (DOH) as a home health agency pursuant to 7.28.2.1 NMAC et seq.

ii. Respite services may be provided by agencies approved by HSD/MAD.

iii. Respite agencies must comply with DOH abuse registry screening laws regulations in accordance with the Department of Health Act, NMSA 1978, section 90706(E) and the Employee Abuse Registry Act, NMSA 1978, Sections 24-27-1 to 24-27-8.

iv. Respite agencies must provide incident management and review on an annual basis. Maintain documentation in the employee’s personnel file as required by HSD/MAD.

v. Respite agencies must comply with all requirements set forth in the Medicaid Provider Participation Agreement (MPPA).

vi. Respite agencies must have available and maintain a roster of trained and qualified respite employee(s) for back-up or regular scheduling and emergencies. For members whose health and welfare will be at risk due to absence, there should be a back-up plan that ensures the member’s health and safety.

vii. Respite agencies must have available in the member’s home a current copy of the Care Plan and any additional materials/instructions related to the member’s care.

viii. Training of the bowel & bladder care must be taught by a Registered Nurse with a current license to practice in the state of New Mexico. Upon completion the respite staff must demonstrate competencies to perform individualized bowel and bladder programs. No respite staff will provide bowel and bladder services prior to completion of the initial training.

ix. Respite supervisors must provide specific instructions to assigned respite staff on each member prior to providing services to the member.

x. Respite agencies must ensure written notification to the MCO and provide the MCO with a copy of the incident report.

3. REIMBURSEMENT

Respite provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the
Medicaid Provider Participation Agreement (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for respite services will be based on the negotiated rate with the MCOs. Providers of respite services have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4 LIMITS or EXCLUSIONS:
   a. Respite services may not be provided to the member by his or her spouse.
   b. Respite services cannot be included in the Care Plan in combination with Assisted Living.
   c. Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caretaker. Additional hours may be requested if an eligible member’s health and safety needs exceed the specified amount.
   d. For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 calendar days.

5 AUTHORIZATION OF PERSONAL CARE RESPITE SERVICES:
   a. Scheduling of hours for use of Respite Services will be the responsibility of the member of service or their representative.
   b. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement.
   c. The provider of Respite Services must maintain a cumulative record of utilization of respite care, to include time used.
   d. The member cannot schedule his or her own respite with the respite staff.
   e. The member may receive a maximum of 100 hours annually per Care Plan year provided there is a primary caregiver.

6 OTHER:
Under no circumstances may a respite staff act on behalf of a member as their representative in matters regarding medical treatment, financial, legal or budgetary decision-making, and/or manage a member’s finances. An immediate referral must be made to the MCO in order to determine if the member should be referred to an appropriate social service or legal services agency(s) for assistance in these areas.
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.

1. LIMITS or EXCLUSIONS
   A signed therapy referral for treatment must be obtained from the member’s primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered
OCCUPATIONAL THERAPY FOR ADULTS

Occupational therapy is a skilled therapy service for individuals 21 years and older provided by a licensed Occupational Therapist. Occupational Therapy services promote/maintain fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. A signed occupational 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 occupational therapist 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). Specific services may include the following:

1. SCOPE OF SERVICES
   a. Teaching daily living skills;
   b. Developing perceptual motor skills and sensory integrative functioning;
   c. Designing, fabricating or modifying of assistive technology or adaptive devices;
   d. Providing assistive technology services;
   e. Designing, fabricating or applying of selected orthotic or prosthetic devices or selecting adaptive equipment;
   f. Using specifically designed crafts and exercise to enhance functional performance;
   g. Training regarding OT activities;
   h. Consulting or collaborating with other service providers or family members, as directed by the member; and/or
   i. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.

2. SERVICE REQUIREMENTS
   a. The occupational therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO care coordinator. Services may include the following:
      i. Obtaining pertinent medical history.
      ii. Assessing of the member for specific needs in gross/fine motor skills pertinent to occupational therapy.
      iii. Adapting the member’s environment in order to meet his/her needs.
      iv. Evaluating, administrating and interpreting tests.
      v. Assessing, interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that is objective and measurable with a statement on potential to achieve goals.
vi. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.

vii. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
   a) Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
   b) Identify short-and long-term goals that are measurable, objective, and related to functional mobility as determined by medical history and evaluative findings.
   c) Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy, treatment/procedures to be rendered, member’s response to treatment, and progress toward therapy goals with dates and time of service.
   d) Review physician’s request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
   e) Implement and administer appropriate treatment.

viii. Providing the member or caregiver education and documenting in the member’s medical record.

ix. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional, sensory/perceptual, and physical and status of all levels and follow-up recommendations as indicated.

b. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.

c. Therapy services may be provided at:
   a) A community based center, i.e. therapy center.
   b) The member’s home.
   c) Any other location in which the member engages in day-to-day activities.

d. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS
   a. Staffing Requirements
      i. Graduation from an accredited occupational therapy program and current licensure as required by New Mexico State law.
      ii. Must have a current licensure by state of New Mexico.
iii. Occupational therapy experience preferably in home care and general acute care.
iv. Must have access to all required diagnostic and therapeutic materials to provide services.
v. Must be proficient in the member’s primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
vi. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.
vii. Certified Occupational Therapy Assistants (COTA) may perform Occupational therapy procedures and related tasks pursuant to a Plan of Care written by the supervising licensed occupational therapist. A COTA must be supervised by a licensed occupational therapist. All related tasks and procedures performed by a COTA must be within a COTA scope of service following all federal and state requirements applicable to COTA services.

b. Administrative Requirements

i. Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.

ii. Provider agencies will establish and maintain financial reporting and accounting for each individual.

iii. All services must be under the order of the member’s Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the Care Coordinator.

iv. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination, and evaluation. There must be justification in each member’s clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity.

a. Payment for occupational therapy services through the MCO is considered payment in full.
b. Occupational Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.

c. Billable hours are as follows:
   i. Face-to-face activities described in the Scope of Service.
   ii. Maximum of eight (8) hours for an initial comprehensive individual assessment.
   iii. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
   iv. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
   v. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
   vi. Annual maximum of eight (8) hours to arrange assistive technology development.
   vii. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
   viii. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

d. The MCO does not consider the following to be professional occupational therapy services and will not authorize payment for the following non-billable activities:
   i. Performing specific errands for the individual and/or family that are not program specific.
   ii. Friendly visiting.
   iii. Financial brokerage services, handling of member finances, or, preparation of legal documents.
   iv. Time spent on paperwork or travel that is administrative for the provider.
   v. Transportation of members.
   vi. Pick up and/or delivery of commodities.
   vii. Other non-Medicaid reimbursable activities.

e. Occupational therapy services are provided with the understanding that the MCO is the payer of last resort. Occupational therapy services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

f. Occupational therapy providers must ensure all insurance records are maintained correctly.

g. Reimbursement for occupational therapy services will be based the negotiated rates with the MCO. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct.
If the provider identifies an error they will contact the MCO immediately to have the error corrected.
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). Specific services may include the following;

1. SCOPE OF SERVICES
   a. Providing professional assessment(s) of the individual for specific needs in gross/fine motor skills;
   b. Developing, implementing, modifying and monitoring physical therapy treatments and interventions for the member;
   c. Designing, modifying or monitoring use of related environmental modifications;
   d. Designing, modifying and monitoring use of related activities supportive to the Care Plan goals and objectives;
   e. Consulting or collaborating with other service providers or family members, as directed by the participant;
   f. Using of equipment and technologies or any other aspect of the member’s physical therapy services;
   g. Training regarding physical therapy activities;
   h. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.

2. SERVICE REQUIREMENTS
   a. The physical therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO Care Coordinator. Services may include the following:
      i. Obtaining pertinent medical history.
      ii. Assessing of the member on physical strengths and deficits including, but limited to:
         a) Range of motion for all joints.
         b) Muscle strength, gait pattern, sensation, balance, coordination, and perception.
         c) Skin integrity and respiratory status.
      iii. Functional level of motor developmental level.
      iv. Adapting the member’s environment in order to meet his/her needs.
v. Evaluating, including the administration and interpreting tests and measurements within the scope of the practitioner;

vi. Assessing interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that are objective and measurable with a statement on potential to achieve goals.

vii. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.

viii. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.

ix. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.

x. Identify short-and long-term goals that are measurable, objective, and related to functional mobility as determined by medical history and evaluative findings. Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy, treatment/procedures to be rendered, member’s response to treatment, and progress toward therapy goals with dates and time of service.

xi. Review physician’s request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.

xii. Implement and administer appropriate treatment.

xiii. Providing the member or caregiver education and documenting in the member’s medical record.

xiv. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional mobility level and follow-up recommendations as indicated.

b. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.

i. Therapy services may be provided at:
   a) A community based center, i.e. therapy center.
   b) The member’s home.
   c) Any other location in which the member engages in day-to-day activities.

c. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS

   a. Staffing Requirements

      i. Graduation from an accredited physical therapy program and current licensure as required by New Mexico State law.
ii. Must have a current licensure by state of New Mexico.
iii. Physical therapy experience preferably in home care and general acute care.
iv. Must have access to all required diagnostic and therapeutic materials to provide services.
v. Must be proficient in the member’s primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
vi. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.
vii. Certified Physical Therapy Assistants (PTA) may perform Physical therapy procedures and related tasks pursuant to a Plan of Care written by the supervising licensed physical therapist. A PTA must be supervised by a licensed physical therapist. All related tasks and procedures performed by a PTA must be within a PTA scope of service following all federal and state requirements applicable to PTA services.

b. Administrative Requirements

i. Provider agencies must adhere to HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.

ii. All services must be under the order of member’s Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the MCO Care Coordinator.

iii. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of the physical therapy service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of physical therapy, including assessment information, care planning, intervention, communications, and evaluation. There must be justification in each member’s clinical record supporting medical necessity for the physical therapy and for the level or intensity (frequency and duration) of the physical therapy service. All services provided, claimed, and billed must have documented justification supporting medical necessity.

a. Payment for physical therapy services through the MCO is considered payment in full.
b. Physical Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.
c. Billable hours are as follows:
i. Face-to-face activities described in the Scope of Service.
   a) Maximum of eight (8) hours for an initial comprehensive individual assessment.
   b) Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
   c) Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
   d) Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
   e) Annual maximum of eight (8) hours to arrange assistive technology development.
   f) Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
   g) Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

d. The HSD/MAD does not consider the following to be professional physical therapy services and will not authorize payment for the following non-billable activities:
   i. Performing specific errands for the individual and/or family that are not program specific.
   ii. Friendly visiting.
   iii. Financial brokerage services, handling of member finances, or, preparation of legal documents.
   iv. Time spent on paperwork or travel that is administrative for the provider.
   v. Transportation of members.
   vi. Pick up and/or delivery of commodities.
   vii. Other non-Medicaid reimbursable activities.

e. Physical therapy services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

f. Physical therapy providers must ensure all insurance records are maintained correctly.

g. Reimbursement for physical therapy services will be based on the current negotiated rate with the MCO for the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
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). Specific services may include the following:

1. SCOPE OF SERVICES
   a. Identification of communicative or oropharyngeal disorders and delays in the development of communication skills.
   b. Prevention of communicative or oropharyngeal disorders and delays in the development of communication skills;
   c. Use of specifically designed equipment, tools, and exercises to enhance functional performance;
   d. Design, fabrication or modification of assistive technology or adaptive devices;
   e. Provision of assistive technology services;
   f. Evaluation, including administering and interpreting tests;
   g. Adapting the member’s environment in order to meet his/her needs;
   h. Implementation of the maintenance therapy plan;
   i. Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up;
   j. Consulting or collaborating with other service providers or family members;
   k. Development of eating or swallowing plans and monitoring their effectiveness.

2. SERVICE REQUIREMENTS
   a. The speech-language therapist must perform a comprehensive assessment evaluation for each member to determine appropriate therapy and coordinate services with the MCO Care Coordinator. Services may include the following:
      i. Obtaining pertinent medical history.
      ii. Assessing for speech-language disorders.
      iii. Assessing for swallowing disorders (dysphasia).
      iv. Assessing of communicative functions including underlying processes (i.e. cognitive skills, memory, attention, perception, and auditory processing,
includes ability to convey or receive a message effectively and independently, regardless of the mode).

v. Assessing of oral motor function.
vii. Assessing of resonance and nasal airflow.
viii. Assessing of orofacial myofunctional patterns.
ix. Assessing interpretation and summary of objective evaluation findings, identification of functional problems, and determining treatment goals that are objective and measurable with a statement on potential to achieve goals.
x. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
xi. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
xii. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
xiii. Identify short-and long-term goals that are measurable, objective, and related to augmentative/alternative communication and/or device treatment/orientation, orofacial myofunctional treatment, prosthetic/device treatment/orientation, swallowing function treatment, voice treatment, central auditory processing treatment, etc.
xiv. Formulate a treatment plan to achieve the goals identified. The treatment plan should include frequency, estimated duration of therapy, treatment/procedures to be rendered, member’s response to treatment, and progress toward therapy goals with dates and time of service.
xv. Review physician’s request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
xvi. Implement and administer appropriate treatment.
xvii. Providing the member or caregiver education and documenting in the member’s medical record.
xviii. Preparing Discharge Summary and include the number and types of treatment provided. The member disposition at discharge including functional, sensory/perceptual, and physical and status of all levels and follow-up recommendations as indicated.
xix. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.
xx. Therapy services may be provided at:
   1. A community based center, i.e. therapy center.
   2. The member’s home.
3. Any other location in which the member engages in day-to-day activities.

b. Therapy services require face-to-face contact, except that non face-to-face consultation and individual-specific assistive technology development is allowable according to limits specified in the reimbursement section of these standards.

3. AGENCY PROVIDER REQUIREMENTS

a. Staffing Requirements

i. Graduation from an accredited masters or doctoral degree level, and holding the Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA).
ii. Must have a current licensure by state of New Mexico.
iii. Speech-language therapy experience preferably in home care and general acute care.
iv. Must have access to all required diagnostic and therapeutic materials to provide services.
v. Must be proficient in the member’s primary language or have access to an interpreter (family member, friend, or caregiver). Professional interpretation service fees are the responsibility of the agency.
vi. Must be culturally sensitive to the needs and preferences of members and their households based upon language. Communicating in a language other than English may be required.

b. Administrative Requirements

i. Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background check, Labor Laws, etc.
ii. Provider agencies will establish and maintain financial reporting and accounting for each individual.
iii. All services must be under the order of the member’s Primary Care Physician. The order will be obtained by the Skilled Therapist, and shared with the MCO.
iv. Therapy reports must be current and available upon request of HSD/MAD.

4. REIMBURSEMENT

Each provider of a service is responsible to provide clinical documentation that identifies his or her role in all components of the provision of home care, including assessment information, care planning, intervention, communications, care coordination, and evaluation. There must be justification in each member’s clinical record supporting medical necessity for the care and for the level or intensity (frequency and duration) of the care. All services must be reflected on a Care Plan
that is coordinated with the member/member representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity.

a. Payment for speech-language therapy services through the MCO is considered payment in full.
b. Speech-Language Therapy services must abide by all federal, state, HSD policies and procedures regarding billable and non-billable items.
c. Billable hours are as follows:
   i. Face-to-face activities described in the Scope of Service.
   ii. Maximum of eight (8) hours for an initial comprehensive individual assessment.
   iii. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
   iv. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
   v. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
   vi. Annual maximum of eight (8) hours to arrange assistive technology development.
   vii. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
   viii. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
d. HSD/MAD does not consider the following to be professional speech language therapy services and will not authorize payment for the following non-billable activities:
   i. Performing specific errands for the individual and/or family that are not program specific.
   ii. Friendly visiting.
   iii. Financial brokerage services, handling of member finances, or, preparation of legal documents.
   iv. Time spent on paperwork or travel that is administrative for the provider.
   v. Transportation of members.
   vi. Pick up and/or delivery of commodities.
   vii. Other non-Medicaid reimbursable activities.
e. Speech-language therapy services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party
liability or other payment sources, these sources must be accessed before ABCB services are delivered.
f. Speech-language therapy providers must ensure all insurance records are maintained correctly.
g. Reimbursement for speech-language therapy services will be based on the current negotiated rate with the MCO for the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
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C. **SELF-DIRECTED COMMUNITY BENEFIT (SDCB)**

1. **Purpose**

The Self Directed Community Benefit (SDCB) is intended to provide a community-based alternative to institutional care that facilitates greater member choice, direction and control over services and supports.

SDCB provides self-directed home and community-based services to eligible members who are living with disabilities and/or conditions associated with aging, certain traumatic or acquired brain injuries (BI), and acquired immunodeficiency syndrome (AIDS).

2. **Guiding principles**

All members:
- Have value and potential;
- Will be viewed in terms of their abilities;
- Have the right to participate and be fully included in their communities; and
- Have the right to live, work, learn, and receive services and supports to meet their individual needs, in the most integrated settings possible within their community.

3. **Philosophy of Self-Direction**

Self-direction is a tool that leads to self-determination, through which members can have greater control over their lives and have more freedom to lead a meaningful life in the community. Within the context of SDCB, self-direction means members choose which services, supports and goods they need. Members also decide when, where and how those SDCB services and supports will be provided and who they want to provide them. Members decide who they want to assist them with planning and managing their SDCB services and supports within a managed care environment. Self-direction means that members have more choice, control, flexibility, freedom and responsibility.

4. **Definitions and Acronyms**

   a. **Authorized Agent (AA)** – The individual that has been legally appointed by the appropriate court to act on behalf of the eligible member as stated in the court’s order. The member authorized agent may be a service provider (depending on scope of the court’s order) for the member. An authorized agent that is also an employee cannot sign his or her specific timesheet.

   b. **Authorized Representative** – The member may choose to appoint an authorized representative designated to have access to medical and financial information for the purpose of offering support and assisting the member in understanding community benefit services. The member may designate a person to act as an authorized representative by signing a release of information form indicating the member’s consent to the release of confidential information. The
authorized representative will not have the authority to direct SDCB. Directing services remains the sole responsibility of the member or his/her legal representative. The member’s authorized representative does not require a legal relationship with the member. While the member’s authorized representative can be a service provider for the member, the authorized representative cannot serve as the member’s care coordinator/support broker. If the authorized representative is an employee, he/she cannot sign his/her own timesheet.

c. Centers for Medicare and Medicaid Services (CMS) – federal agency within the United States Department of Health and Human Services that works in partnership with the states to administer Medicaid. CMS must approve all Medicaid programs.

d. Employer of Record (EOR) – Individual responsible for directing the work of SDCB employees. An EOR is responsible for recruiting, hiring, training, supervising and terminating employees, as necessary. The EOR will establish work schedules and tasks and provide relevant training. The EOR will keep track of budget amounts spent on paying employees and for approved services and goods. EORs authorize the payment of timesheets and invoices by the Financial Management Agency (FMA). A member may be his/her own EOR unless the member is a minor, or has a plenary or limited guardianship or conservatorship over financial matters in place. Members may also designate an individual of their choice to serve as their EOR, subject to the EOR meeting the qualifications specified in the SDCB rules. The EOR cannot be a SDCB employee or vendor. The EOR cannot be paid for performing the employer of record functions.

e. Financial Management Agency (FMA) – Contractor that helps implement the approved SDCB Care Plan by paying the member’s workers and vendors and tracking expenditures. Xerox is the current FMA.

f. FOCoSonline – On-line system used by the SDCB FMA for receiving and processing payments. The FOCoSonline system is also used by members care coordinators, and support brokers to develop and submit SDCB care plan/budget requests for MCO/UR review, and to monitor spending throughout the SDCB care plan/budget year.

g. Human Services Department (HSD) – Designated by the Center for Medicare and Medicaid Services (CMS) as the Medicaid administering agency in New Mexico. HSD is also responsible for operating the SDCB Home and Community Based Services for populations that meet the Nursing Facility Level Of Care (Disabled & Elderly, Brain Injury, and AIDS).

h. Legal Representative – A person that is a legal guardian, conservator, power of attorney or otherwise has a court established legal relationship with the member. The member, or representative, must provide documentation to the care coordinator/support broker and FMA of the legal status of the representative and such documentation will become part of the member’s file. The legal representative will have access to member medical and financial information to the extent outlined in the official court documents.
i. **Legally Responsible Individual (LRI)** – A person who has a duty under State law to care for another person. This category typically includes: the parent (biological or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a SDCB member. Payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a SDCB member. Exceptions to this prohibition may be made under extraordinary circumstances specified by the State, utilizing documentation specified by the State and only after approval by the appropriate MCO.

j. **Managed Care Organization (MCO)** – Provides services related to medical eligibility determination and re-determination, and NFLOC for SDCB members. The MCO also performs utilization management duties – review and approval or denial of each individual SDCB care plan.

k. **Managed Care Organization/Utilization Review (MCO/UR)** – Provides services related to medical eligibility determination and re-determination, and NFLOC for SDCB members. The MCO also performs utilization management duties – review and approval or denial of each individual SDCB care plan/budget.

l. **Quality Assurance and Quality Improvement (QA/QI)** – Processes utilized by state and federal governments, programs and providers whereby appropriate oversight and monitoring of community benefits of assurances and other measures provide information about the health and welfare of members and the delivery of appropriate services. This information is then collected, analyzed and used to improve services and outcomes and to meet requirements by state and federal agencies. Quality plans, systems and processes are designed and implemented to maintain continuous quality improvement.

m. **Reconsideration** – Members who disagree with a decision made by the MCO/UR may submit a written request through a care coordinator/support broker to the MCO/UR for a reconsideration of the decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.

n. **Self-Directed Community Benefit (SDCB)** – The State’s 1115(c) Medicaid self-directed community benefit which allows eligible members the option to access Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, member protections, and quality assurance and quality improvement.

o. **SDCB Budget** – The maximum budget allotment available to an eligible SDCB member, determined by his/her established nursing facility level-of-care (NF-LOC) and comprehensive needs assessment (CNA). Based on this maximum amount, the eligible SDCB member will develop a SDCB care plan to meet his/her assessed functional, medical and habilitative needs to enable that member to remain in the community.

p. **SDCB Care Plan** – A plan that includes approved SDCB services of the SDCB member’s choice; the projected cost, frequency and duration of services and goods; the type of provider who will furnish each service or good; other services and goods to be used by the member (regardless of funding source, including
State Plan services); and the member’s available natural and informal supports that will complement SDCB services in meeting the needs of the member. Each SDCB care plan shall include a back-up plan which lists who the member will contact if regularly scheduled employees or service providers are unable to report to work. **The SDCB care plan and back-up plan are mandatory for all SDCB members and must be processed through the FOCoS online system.**

q. **SDCB Member** – An individual who meets the medical and financial eligibility and is approved to receive services through the SDCB.

r. **Self-Direction** – Process applied to the service delivery system wherein members have choices (among the state-determined SDCB services and goods) in identifying, accessing and managing the services and goods they obtain to meet their personal assistance and other health-related needs. Self-direction means more choices and flexibility in planning for needed supports, services, and goods.

s. **Support Broker (SB)** – Provides support to SDCB members that assist the member (or the member’s family or representative, as appropriate) in arranging for, directing and managing SDCB services and supports as well as developing, implementing and monitoring the SDCB care plan and budget. Individual support brokers work for MCO-approved support broker agencies or may be directly employed with a MCO.

### 5. SDCB Member Rights

A SDCB member has the right to:

- Decide where and with whom to live;
- Choose his/her own work or productive activity;
- Choose how to establish community and personal relationships;
- Make decisions regarding his/her own support, based upon informed choice;
- Be respected and supported during the decision-making process and in the decisions made;
- Hire, train, schedule, supervise and dismiss service providers, as necessary;
- Receive training, resources and information related to SDCB in a format that meets the American with Disabilities Act (ADA) requirements;
- Have the right to appeal denials or decisions through the MCO appeals and state fair hearing processes;
- Transfer to programs that are not self-directed; and
- Receive culturally competent services.

### 6. SDCB Member Responsibilities

SDCB members have certain responsibilities in order to participate in the program. Failure to comply with these responsibilities or other program rules can result in termination from the SDCB.
The most basic responsibility of a SDCB member is to maintain their financial and medical eligibility to be in the program. This includes completing the required documentation to determine financial eligibility and participating in the annual comprehensive needs assessment of Level of Care (LOC) conducted by the Managed Care Organization (MCO). The care coordinator and support broker are available to assist with the application and recertification process as needed.

a. On-going SDCB member responsibilities include:
   i. Comply with the rules that govern the SDCB;
   ii. Maintain an open and collaborative relationship with the care coordinator and support broker, and work together to determine support needs related to the activities of self-direction, develop an appropriate SDCB care plan/budget request, receive necessary assistance with carrying out the approved SDCB care plan/budget and with documenting service delivery;
   iii. Communicate with the support broker at least once a month, either in person or by phone, and meet with the support broker in-person at least once every three (3) months. Report concerns or problems with any part of SDCB to the support broker or care coordinator;
   iv. Use program funds appropriately by only requesting services and goods covered by the SDCB and only purchasing services and goods after they have been approved by the MCO/UR;
   v. Comply with the approved SDCB care plan and not spend more than authorized budget;
   vi. Work with the care coordinator by attending scheduled meetings and assessments, in the member’s home if necessary, and providing documentation as requested;
   vii. Respond to requests for additional documentation and information from the support broker, Fiscal Management Agency (FMA), and the MCO/UR within the required deadlines;
   viii. Report to the local Income Support Division (ISD) office, within 10 business days, any change in circumstances, including a change in address or hospitalization, which might affect eligibility for the program. Changes in address or other contact information must also be reported to the service coordinator, support broker and the FMA within 10 calendar days;
   ix. Report to the service coordinator and support broker if hospitalized for more than three (3) consecutive nights so that a new appropriate LOC can be obtained; and
   x. Communicate with SDCB service providers, State contractors and State personnel in a non-abusive and non-threatening manner.
b. The SDCB member/EOR also has specific responsibilities related to being an employer. These include:

i. Arranging for the delivery of services, supports and goods as approved in the SDCB care plan;

ii. Verifying and attesting that employees meet the minimum qualifications for employment as required by the SDCB;

iii. Orienting, training, and directing employees in providing the services that are described and authorized in the member’s SDCB care plan;

iv. Establishing a mutually agreeable schedule for employees’ services in writing and providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;

v. Submitting all required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the State. Documents include, but are not limited to, vendor and employee agreements, vendor information forms, criminal background check forms, timesheets, payment request forms (PRFs) and invoices, updated employee information, and other documentation needed by the FMA to process payment to employees and vendors;

vi. Agreeing that employees may not begin work until all materials necessary for a criminal background check have been received by the FMA and the employee has successfully passed the Consolidated Online Registry (COR) Background Check.

vii. Agreeing to select or employ the employee on an interim (temporary) basis until a final criminal history record check has been successfully completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3. The employer discusses this with the employee and reserves the right to dismiss the employee based on the results of the criminal history record check.

viii. Providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;

ix. Authorizing completed employee timesheets in order to pay employees according to the FMA predetermined payroll schedule. Net wages will include gross earnings calculated according to the employee’s pay rate, minus payroll deductions for the employee’s share of applicable state, federal, and local payroll withholdings;

x. Reporting any incidents of abuse, neglect or exploitation by any employee or other service provider to the support broker and/or care coordinator;

xi. Maintaining employee and service records and documentation in accordance with SDCB rules and federal and state employment rules;
xii. Fully cooperating with the NM Department of Workforce Solutions (DWS) in any investigations or other matters related to his/her employees;

xiii. Fully cooperating with the State’s worker’s compensation carrier, currently NM Mutual. Responsibilities include reporting claims and providing information to NM Mutual;

xiv. Meeting federal employer requirements, such as completing and maintaining a federal I-9 form for each employee as required by law; and

xv. When necessary, requesting assistance from the support broker and/or care coordinator with any of these SDCB responsibilities.

7. SDCB Supports

In the SDCB important sources of support and direction for SDCB members are the MCO and the FMA. The MCO determines initial and on-going medical eligibility, reviews and authorizes the SDCB care plan/budget, and provides support to the SDCB member to ensure successful implementation of the SDCB program. The FMA acts as the intermediary between the member and the Medicaid payment system and assists the member or the EOR with employer-related responsibilities.

a. Managed Care Organization

The MCO provides services related to medical eligibility determination and re-determination, and NFLOC for SDCB members. The MCO also performs utilization management duties – review and approval or denial of each individual SDCB care plan/budget. All SDCB members have a care coordinator and a support broker. The care coordinator and support brokers assist the SDCB member with virtually every aspect of SDCB.

The support broker is instrumental in developing the SDCB care plan and provides an additional layer of assistance to ensure successful implementation of the SDCB care plan.

b. Care Coordinator

The care coordinator is responsible for managing the member’s acute care, behavioral health care, home and community based services, and long-term care. In SDCB, the care coordinator is primarily responsible for coordinating all aspects of the member’s care and for determining the SDCB budget. SDCB related assistance includes, but is not limited to:

i. Understanding SDCB member and EOR roles and responsibilities;

ii. Identifying resources outside the SDCB, including natural and informal supports, that may assist in meeting the SDCB member’s needs;

iii. Understanding the array of SDCB covered supports, services, and goods;
iv. Assigning the annual budget for the SDCB, based on the CNA, to address the needs of the member in accordance with the requirements stated in the managed care contract and the member’s Community Benefit
v. Monitoring utilization of SDCB services and goods on a regular basis;
vii. Conducting employer-related activities such as assisting a SDCB member in identifying a designated EOR (as appropriate);
viii. Identifying and resolving issues related to the implementation of the SDCB care plan/budget;
viii. Assisting the SDCB member with quality assurance activities to ensure implementation of the SDCB member’s SDCB care plan/budget, and utilization of the authorized budget;
ix. Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;
x. Monitoring quality of services provided by support brokers; and
xi. Working with the member to provide the necessary assistance for successful program implementation.

c. Support Broker
Support broker services may be provided by direct MCO personnel or by Support Broker Agencies subcontracted by the MCO. Support broker services are direct services intended to educate, guide and assist the SDCB member to make informed planning decisions about services and supports, to develop a SDCB care plan/budget that is based on the SDCB member’s assessed needs and to assist the SDCB member with quality assurance related to the SDCB care plan/budget.

Support broker services provide a level of support to a SDCB member that is unique to their individual needs in order to maximize their ability to self-direct in the SDCB. SDCB members may choose to work with any MCO-approved support broker in their region.

i. The extent of assistance is based upon individual member needs, and includes, but is not limited to, providing help and guidance to:

a. Educate members on how to use self-directed supports and services and provide information on program changes or updates;
b. Review, monitor and document progress of the member’s SDCB care plan;
c. Assist in managing budget expenditures and complete and submit budget revisions;
d. Assist with EOR functions such as recruiting, hiring and supervising providers;
e. Assist with approving/processing job descriptions for direct supports;
f. Assist with completing forms related to employees;
g. Assist with approving timesheets and purchase orders or invoices for goods, obtaining quotes for services and goods as well as identifying and negotiating with vendors;

h. Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;

i. Facilitate resolution of any disputes regarding payment to providers for services rendered;

j. Develop the care plan for SDCB, based on the budget amount; and

k. Assist in completing all documentation required by the FMA.

ii. Support brokers will contact the SDCB member in person or by telephone at least monthly for a routine follow-up. Support brokers will meet in person with the member at least quarterly; one visit must be conducted in the member’s home. Support brokers will, at a minimum:

a. Review spending patterns;

b. Review and document progress of SDCB care plan/budget implementation;

c. Document the usage and effectiveness of the SDCB backup plan; and

d. Document the purchase of goods.

d. **Financial Management Agent**

The Financial Management Agent (FMA) is under contract with the MCOs to provide payment for SDCB services and goods which are approved on the SDCB budget/care plan.

i. The FMA is responsible for providing the following services in the SDCB program:

a. Assure program compliance with state and federal employment and IRS requirements;

b. Assist each SDCB member/EOR to set up a unique Employer Identification Number (EIN) if they intend to hire employees;

c. Answer member inquiries, solve related problems, and offer periodic trainings for SDCB members and their representatives on how to handle the SDCB billing and invoicing processes. The FMA will provide all SDCB members with necessary documents, instructions and guidelines;

d. Collect all documentation necessary to verify that providers and vendors have the qualifications and credentials required by the SDCB rules;

e. Collect all documentation necessary to support the SDCB member’s specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;

f. Successfully complete criminal history and/or background investigations for service providers, pursuant to 7.1.9 NMAC and in accordance with 1978 Section 29-17-1 NMAC of the Caregivers Criminal History Screening Act;
g. Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC Consolidated Online Registry (COR), to determine whether service providers or employees of SDCB members are included in the registry. If a provider or employee is listed in the Abuse Registry, that person may not be employed by a SDCB member;

h. Process and pay invoices for services and goods that are approved in the SDCB member’s care plan/budget, when supported by required documentation;

i. Handle all payroll functions on behalf of the SDCB members who hire direct service employees and other support personnel, including collecting and processing timesheets of support workers, processing payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurances;

j. Track and report on employee payment disbursements and balances of SDCB member funds, including providing the SDCB member and his/her care coordinator/support broker with a monthly report of expenditures and budget status; and

k. Report any concerns related to the health and safety of a SDCB member or that the SDCB member is not following the approved SDCB care plan/budget to the care coordinator/support broker, HSD/MAD and DOH/DDSD, as appropriate.

ii. FOCoSonline

a. In addition to the above functions, the FMA operates FOCoSonline. FOCoSonline is a web-based system that is used for FMA functions such as tracking the credentialing status of employees and vendors, timesheet submission, payment processing for employees and vendors, and tracking the SDCB care plan/budget expenditures.

b. FOCoSonline is also used by SDCB members, support brokers and care coordinator to develop and submit a SDCB care plan/budget for MCO/UR review.

c. The MCO/UR uses FOCoSonline to receive SDCB care plan/budget requests and request additional information from the SDCB member and care coordinator/support broker, and to indicate what SDCB services, supports and goods have been approved or denied.

d. The FMA will provide SDCB members and care coordinator/support brokers with training and access for FOCoSonline, as well as on-going technical assistance and help with problem solving.
8. Planning and Budgeting for SDCB Services and Goods

a. SDCB Care Plan Development Processes

The SDCB care plan development process starts with person-centered planning. In person-centered planning, the SDCB care plan must revolve around the individual SDCB member and reflect his or her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the planning process is for the SDCB member to achieve a meaningful life in the community, as defined by the SDCB member. Upon enrollment in SDCB and choosing his/her support broker, each SDCB member shall receive a budget amount (that is determined by the MCO based on the results of the CNA) and information and training from the care coordinator and/or support broker about covered SDCB services and the requirements for the content of the SDCB care plan.

The SDCB member is the leader in the development of the SDCB care plan. The SDCB member will take the lead, or be encouraged and supported to take the lead to the best of their abilities, to direct development of the SDCB care plan. If the SDCB member desires, he/she may include family members or other individuals, including service workers or providers, in the planning process. The SDCB care plan is entered into FOCoSonline by the supports broker.

Once the SDCB care plan has been completed and the SDCB member has identified the goals he/she would like to accomplish through the SDCB program, the care coordinator/support broker and member work together to develop the SDCB care plan/budget request. The SDCB member and care coordinator/support broker may need to research the estimated cost of services and goods, and will use the SDCB Range of Rates chart (Appendix C) to determine appropriate rates of pay for potential employees and vendors.

The SDCB care plan/budget is developed one (1) goal at a time. Each goal shall include a clear and complete explanation of the requested service(s) or good(s), how they are related to the SDCB member’s condition and why they are appropriate for the SDCB member.

In addition, each goal includes full details about each of the requested service(s) or good(s), including, but not limited to: amount, frequency, cost or estimated cost, rate of pay.

The SDCB care plan/budget request is developed by the SDCB member and the care coordinator/support broker. Once the SDCB care plan/budget request is complete and approved by the SDCB member, the care coordinator/support broker will submit it to the MCO/UR for consideration using FOCoSonline. Annual SDCB care plan/budget
requests shall be submitted to the MCO/UR no later than 30 calendar days prior to the end of the current SDCB care plan/budget year.

b. SDCB Member’s Employer Authority
The EOR is the common-law employer of service providers. The FMA serves as the SDCB member’s agent in conducting payroll and other employer-related responsibilities that are required by federal and state law.

c. SDCB Member Decision-Making Authority
Members shall have authority to do the following:

i. Complete the employer paperwork to be submitted to the FMA;
ii. Determine the amount paid for SDCB services within the State’s approved limits (Range of Rates, Appendix C.);
iii. Schedule the provision of services;
iv. Specify service provider qualifications of the SDCB member’s choice, consistent with the qualifications specified in the SDCB rules and the Policy Manual;
v. Specify how services are provided, consistent with the SDCB rules and the Program Policy Manual;
vi. Identify service providers and vendors and refer them to the FMA for enrollment;
vii. Arrange to have service providers paid for the approved SDCB services by ensuring that all proposed employees and service providers complete all FMA required paperwork, including a criminal background check when necessary. Payment for services and goods cannot be made until paperwork is complete and approved by the FMA;
viii. Review, approve and submit provider timesheets to the FMA within established timeframes. Timesheets may be submitted to the FMA by fax or through FOCoSonline. Failure to submit provider timesheets within the required timeframes will result in providers not being paid in accordance with the employee payroll schedule;
ix. Approve payment, according to the SDCB care plan/budget, for approved services and goods identified in the approved SDCB Care Plan. The member must submit an invoice or receipt from a vendor for any item he/she has an approved goal and budget to purchase;
x. SDCB members cannot/will not be reimbursed directly for any services, supports and/or goods;
xi. The SDCB member shall follow the SDCB care plan;
{xii. The SDCB member shall work with the FMA to have all employees, providers and vendors approved and enrolled prior to delivery or provision of any service or good; and
xiii. The SDCB member shall be accountable for the use of SDCB funds.

9. **SDCB qualifications for all SDCB members, employees, independent providers, provider agencies, and vendors**

In order to be approved as an individual employee, an independent provider, a provider agency (excluding support broker providers which are covered later in this document) or a vendor, each entity must meet the general and service specific qualifications found in the Self-Directed Community Benefit (SDCB) rules and submit an employee or vendor enrollment packet, specific to the provider or vendor type, for approval to the Financial Management Agency (FMA).

In order to be an authorized provider for SDCB and receive payment for delivered services, the provider must complete and sign an employee or vendor provider agreement and all required tax documents. The provider’s credentials must be verified by the member/employer of record (EOR) and the FMA.

a. General qualifications for individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies who are employed by a SDCB member to provide direct services:
   
   i. be at least 18 years of age;
   
   ii. be qualified to perform the service and demonstrate capacity to perform required tasks;
   
   iii. be able to communicate successfully with the member;
   
   iv. pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
   
   v. complete training on critical incident, abuse, neglect, and exploitation reporting;
   
   vi. complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; the member is also responsible for providing and arranging for employee training and supervising employee performance; training expenses for paid employees cannot be paid for with the SDCB member’s annual budget;
   
   vii. meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and
   
   viii. maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

b. General qualifications for vendors, including those providing professional services:

   i. be qualified to provide the service;
ii. possess a valid business license, if applicable;
iii. if a professional provider, be required to follow the applicable licensing regulations set forth by the profession; refer to the appropriate New Mexico board of licensure for information regarding applicable licenses;
iv. if a support broker provider, meet all of the qualifications set forth in 8.308.12 NMAC;
v. if a currently approved SDCB provider, be in good standing with the appropriate state agency; and
vi. meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC).
vii. maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

c. General qualifications for Legally Responsible Individuals (LRIs) who provide services:

i. LRIs, e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a SDCB member, may be hired and paid for provision of SDCB services (except support broke and community supports services) under extraordinary circumstances in order to assure the health and welfare of the member, to avoid institutionalization and provided that the state is eligible to receive federal financial participation (FFP).
ii. Extraordinary circumstances include the inability of the LRI to find other qualified, suitable caregivers when the LRI would otherwise be absent from the home and, thus, the caregiver must stay at home to ensure the member’s health and safety.
iii. LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness.

d. Hiring of LRIs must be approved in writing by the appropriate MCO/UR staff member. Services provided by LRIs must:

i. meet the definition of a service or support and be specified in the member’s approved SDCB care plan and budget;
ii. be provided by a parent or spouse who meets the provider qualifications and training standards specified in the SDCB rules and these service descriptions and qualifications for that service; and
iii. be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and be approved by the MCO/UR.
10. Ongoing Support Broker Services

a. Definition of Service

Support broker services are intended to educate, guide and assist the SDCB member to make informed planning decisions about services and supports. This leads to the development of a SDCB care plan, based on the member’s assessed needs.

Support broker services help the member identify supports, services and goods that meet their need for SDCB services and are specific to the member’s disability or qualifying condition and help prevent institutionalization.

Support Broker services provide a level of support to a member that is unique to their individual needs in order to maximize their ability to successfully self-direct in the SDCB.

b. Scope of Service

i. Support broker services and supports are delivered in accordance with the member’s identified needs. Based upon those needs, the support broker shall:

   a. Provide the member with information, support and assistance during the annual Medicaid eligibility processes, including the medical level of care (LOC) evaluation and financial eligibility processes;
   b. Assist existing members with annual LOC requirements within ninety (90) calendar days prior to the expiration of the LOC;
   c. Schedule member enrollment meetings within five (5) business days of notification and support broker agency selection. The actual enrollment meeting should be conducted within 30 calendar days. Enrollment activities include but are not limited to:
      i. General program overview including key agencies and contact information;
      ii. Discuss eligibility requirements and offer assistance in completing these requirements as needed;
      iii. Discuss member roles and responsibilities;
      iv. Discussion of Employer of Record (EOR) including discussion and possible identification of an EOR and completion of the EOR information form;
      v. Review the processes for hiring employees and contractors and required paperwork;
      vi. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees;
      vii. Discuss the background check and other credentialing requirements for employees and contractors;
      viii. Referral for accessing training for the FOCoSonLine system; and to obtain information on the Financial Management Agency (FMA);
ix. Provide information on the SDCB care plan including covered goods and services, planning tool and community resources available;

x. For those members transitioning from Agency Based Community Benefit (ABCB), a transition meeting including the transfer of program information must occur prior to the SDCB care plan meeting; and

xi. Schedule the date for the SDCB care plan meeting within 10 business days of the enrollment meeting.

d. Assist the members in utilizing all program assessments, such as the client individual assessment and the CNA to develop the SDCB care plan.

e. Educate members regarding SDCB covered supports, services, and goods.

f. Assist the member to identify resources outside the SDCB that may assist in meeting their needs.

g. Ensure the completion and submission of the SDCB care plan is within 60 calendar days of eligibility determination so that it could be in effect within 90 calendar days.

h. Ensure that the SDCB care plan for each member includes the following:

i. The services and supports, covered by the SDCB, to address the needs of the member as determined through an assessment and person-centered planning process;

ii. The purposes for the requested services, expected outcomes, and methods for monitoring progress must be specifically identified and addressed;

iii. The 24-hour backup plan for services that affect health and safety of members; and

iv. The quality indicators, identified by the member, for the services and supports provided through the SDCB.

i. Ensure that the SDCB care plan is submitted in the appropriate format as prescribed by the state which includes the use of the FOCoS online system.

j. SDCB care plan revisions shall be completed and submitted as needed, in the format as prescribed by the state, which includes the use of the FOCoS online system. No more than one (1) revision is allowed to be submitted at any given time.

k. Ensure the completion and submission of the annual SDCB care plan to the care coordinator and MCO/UR at least 30 calendar days prior to the expiration of the plan so that sufficient time is afforded for MCO/UR review.

i. Provide a copy of the final approved SDCB care plan and budget documents to each member.

ii. Assist the member with the application for LRI as employee process; submit the application to the MCO/UR and assist with the environmental modification process.
iii. Assist members to identify and resolve issues related to the implementation of the SDCB care plan.
iv. Serve as an advocate for the member, as needed, to enhance his/her opportunity to be successful in the SDCB.
v. Assist the member with reconsiderations of goods or services denied by the MCO/UR, submit documentation as required, and participate in MCO appeals process and State Fair Hearings as requested by the member or state.
vi. Assist the member with quality assurance activities to ensure implementation of the member’s SDCB care plan, and utilization of the annual budget.
vii. Assist members to transition to another support broker provider when requested. Transitions should occur within 30 calendar days of SDCB member’s written request, but may occur sooner based on the needs of the member. Transition from one support broker provider to another can only occur at the first of the month.
viii. Assist members to transition from/to ABCB/SDCB. Transition from and to ABCB/SDCB can only occur at the first of the month.
ix. The support broker provider shall provide training to members related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and member deaths. This member training shall also include reporting procedures for employees, members/member representatives, and other designated individuals. (Please refer to the Incident Management procedures for process requirements).

c. Support Broker Functions
Support broker providers shall make contact with the member at least monthly for a routine follow up. This contact can either be face to face or by telephone.

Support Broker providers shall meet in person with the SDCB member at a minimum of once each quarter. It is mandatory that a minimum of one visit per SDCB care plan year is to be held in the member’s residence.

The quarterly visits are for the following purposes:
- Review and document progress on implementation of the SDCB care plan;
- Document any usage and the effectiveness of the 24-hour backup plan;
- Review SDCB care plan and budget spending patterns (over and under utilization);
- Document the member’s access to related goods identified in the SDCB care plan;
• Review any incidents or events that have impacted the member’s health and welfare or ability to fully access and utilize support as identified in the SDCB care plan; and
• Other concerns or challenges as noted by the member/representative.

d. Critical Incident Management Responsibilities and Reporting Requirements
i. The support broker provider shall provide training to members related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and member deaths.

ii. The support broker provider agency will also maintain documentation that each member has been trained on the critical incident reporting process. This member training shall include reporting procedures for members, employees, member representative, and/or other designated individuals.

iii. The support broker provider shall report incidents of abuse, neglect and/or exploitation as directed by the state.

iv. The support broker provider will maintain a critical incident management system to identify, report, and address critical incidents. The support broker provider is responsible for follow-up and assisting the individual to help ensure health and safety when a critical incident has occurred.

v. Critical incident reporting requirements: All incident reports, for the Home and Community Based and Behavioral Health Services population involving Abuse, Neglect, Self-Neglect, Exploitation, Environmental Hazard, Law Enforcement Involvement, and Emergency Services, must be reported to the member’s Care Coordinator, Support Broker or Adult Protective Services.

e. Administrative Requirements
i. The support broker provider shall comply with all applicable federal, state regulations, all policies and procedures governing support broker services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:

a. Have a current business license issued by the state, county or city government as required;

b. Maintain financial solvency;

c. Ensure all employees providing support broker services under this standard attend all state-required orientation and trainings and demonstrate knowledge of and competence with the SDCB policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, needs assessments, person-centered planning and service
plan development, and adhere to all other training requirements as specified by the state;

d. Ensure that all employees are trained and competent in the use of the fiscal management and FOCoSOnline system;

e. Ensure all employees providing services under this scope of service and all other staff are trained on how to identify and where to report critical incidents abuse, neglect and exploitation; and

f. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.

ii. The support broker provider shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous quality improvement.

iii. The support broker provider shall ensure that members have access to the support broker provider. This requirement includes, but is not limited to the following:

a. The support broker provider must maintain a presence in each region for which they are providing services;

b. The support broker provider must maintain a consistent way (for example, phone, pager, email, and fax) for the member to contact the support broker provider during typical business hours which are 8:00 a.m. to 5:00 p.m. Monday through Friday;

c. The support broker provider must maintain a consistent way (for example phone, pager, email, and fax) for the member to contact the support broker provider during non-business hours: prior to 8:00 a.m. and after 5:00 p.m. MST on weekdays and on weekends and for emergency purposes;

d. The support broker provider must provide a location to conduct confidential meetings with members when it is not possible to do so in the member’s home. This location must be convenient for the member and compliant with the Americans with Disabilities Act (ADA);

e. The support broker provider must maintain an operational fax machine at all times; and

f. The support broker provider must maintain an operational email address, internet access, and the necessary technology to access SDCB related systems.

iv. The support broker provider shall maintain a current local/state community resource manual.

v. The support broker provider shall adhere to Medicaid General Provider policies 8.302.1.
vi. The support broker provider shall maintain HIPAA compliant primary records for each member including, but not limited to:

a. Current and historical SDCB care plan and budget;
b. Contact log that documents all communication with the member;
c. Completed/signed quarterly visit form(s);
d. MCO/UR documentation of approvals/denials, including budget and revision requests;
e. MCO/UR correspondence; (requests for additional information, etc);
f. Assessor’s individual specific health and safety recommendations;
g. Notifications of medical and financial eligibility;
h. Budget utilization reports from the FMA;
i. Environmental modification approvals/denials;
j. Legally Responsible Individual (LRI) approvals/denials;
k. Documentation of member and employee incident management training;
l. Copy of legal guardianship or representative papers and other pertinent legal designations; and
m. Copy of the approval form for the authorized representative.

vii. The support broker provider shall ensure the development and implementation of a written grievance procedure in compliance with 8.349.2.11 NMAC.

viii. The support broker provider shall meet all of the qualifications set forth in 8.304.12 NMAC.

f. Support Broker Qualifications
Support broker providers shall ensure that all individuals providing support broker services meet the criteria specified in this section.

i. Support broker providers shall:

a) Be at least 18 years of age;
b) Possess a minimum of a Bachelor’s degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;
c) Have one year of supervised experience working with seniors and/or people living with disabilities;
d) Complete all required SDCB orientation and training courses; and
e) Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

OR
ii. Support broker providers shall:

   a) Be at least 18 years of age;
   b) Have a minimum of six (6) years of direct experience related to the delivery of social services to seniors and/or people living with disabilities;
   c) Be employed by an enrolled support broker provider agency;
   d) Complete all required SDCB orientation and training courses; and
   e) Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC.

   g. Conflict of Interest
      i. The support broker provider may not provide any other direct services for members that have an approved SDCB care plan and are actively receiving services in the SDCB; and
      ii. The support broker provider may not employ, as a support broker, any immediate family member or guardian of a member in the SDCB that is served by the support broker provider.

11. SDCB Covered Services
   Below is a list of SDCB covered services and goods for members in SDCB, followed by a detailed service description,

   a. Behavior Support Consultation Services
   b. Customized Community Support
   c. Emergency Response
   d. Employment Supports
   e. Environmental Modifications
   f. Home Health Aide
   g. Homemaker
   h. Nutritional Counseling
   i. Private Duty Nursing
   j. Related Goods
   k. Respite
   l. Skilled Therapy Services for Adults
   m. Specialized Therapies
   n. Transportation (Non-Medical)
a. **BEHAVIOR SUPPORT CONSULTATION**

i. **Definition of Service**

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

ii. **Scope of Services:**

a. Inform and guide the member, family, employees and/or vendors toward understanding the contributing factors to the member’s behavior;

b. Identify support strategies to enhance functional capacities, adding to the provider’s competency to predict, prevent and respond to interfering behavior and potentially reducing interfering behaviors;

c. Support effective implementation based on a functional assessment and subsequent SDCB care plans;

d. Collaborate with medical and ancillary therapies to promote coherent psychotherapeutic medications; and

e. Monitor and adapt support strategies based on the response of the member and his/her family, employees and/or vendors.

iii. **Behavior Consultant Qualifications – Individual:**

a. Provide a tax identification number;

b. Maintain a member file within HIPAA guidelines to include:
   1. Member’s SDCB care plan;
   2. Reports as requested in the SDCB care plan;
   3. Contact notes; and
   4. Training roster(s).

c. Have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
   1. Medical doctor (M.D.);
   2. Licensed clinical psychologist;
   3. Licensed psychologist associate (masters or PhD level);
   4. Licensed social worker (LISW or LMSW);
   5. Licensed professional clinical counselor (LPCC);
   6. Licensed professional counselor (LPC);
   7. Licensed psychiatric nurse (MSN/RNCS);
   8. Licensed marriage and family therapist (LMFT); or
   9. Licensed practicing art therapist (LPAT).
iv. Behavior Consultant Qualifications - Provider Agency:

a. Provide a tax identification number; and current business license issued by state, county or city government, if required.

b. Maintain a member file within HIPAA guidelines to include:
   1. Member’s SDCB care plan;
   2. Reports as requested in the SDCB care plan;
   3. Contact notes; and
   4. Training roster(s).

c. Ensure therapists have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
   1. Medical doctor (M.D.);
   2. Licensed clinical psychologist;
   3. Licensed psychologist associate (masters or PhD level);
   4. Licensed social worker (LISW or LMSW);
   5. Licensed professional clinical counselor (LPCC);
   6. Licensed professional counselor (LPC);
   7. Licensed psychiatric nurse (MSN/RNCS);
   8. Licensed marriage and family therapist (LMFT); or
   9. Licensed practicing art therapist (LPAT).
b. CUSTOMIZED COMMUNITY SUPPORTS

i. Definition of Service

Customized Community Support Services: 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 can 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.

These services are provided at least four (4) or more hours per day (1) one or more days per week as specified in the member’s SDCB care plan. Customized community supports cannot duplicate employment support services or any other SDCB service.

ii. Scope of Services:

Customized community supports services include, but are not limited to the following:

a. Provide supports in congregate and community day programs that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills;
b. Adult day health services;
c. Adult day habilitation services; and
d. Other day support model services.

iii. Customized Community Supports Qualifications - Provider Agency:

a. Possess a current business license, if applicable;
b. Meet financial solvency;
c. Adhere to training requirements;
d. Maintain member records for each member within HIPAA compliance;
e. Develop and adhere to a records management policy;
f. Develop and adhere to quality assurance rules and requirements; and
g. Adult day health provider agencies must be licensed by NM DOH as an adult day care facility pursuant to 7.13.2 NMAC.

h. Ensure all assigned staff meet the following qualifications:
   1. Be at least 18 years of age;
   2. Have at least one year of experience working with people with disabilities;
   3. Be qualified to perform the service and demonstrate capacity to perform required tasks;
   4. Be able to communicate successfully with the member;
5. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
6. Complete training on critical incident, abuse, neglect, and exploitation reporting;
7. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s budget; and
8. Meet any other service qualifications, as specified in the SDCB rules.
c. EMERGENCY RESPONSE

i. Definition of Service

Emergency response services (ERS) 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.

ii. Scope of Services:

a. Testing and maintaining equipment;
b. Training members, caregivers and first responders on the use of the equipment;
c. Twenty-four (24) hour monitoring for alarms;
d. Checking systems monthly or more frequently if warranted (e.g. electrical outages, severe weather);
e. Reporting member’s condition that may affect service delivery; and
f. Initial set-up and installation of ERS devices is not a covered service.

iii. Emergency Response Qualifications – Vendor/Agency:

a. Comply with all laws, rules and regulations of the New Mexico State Corporation Commission for Telecommunications and Security Systems; and
b. Comply with all laws, rules and regulations from the federal Trade Communication Commission (FCC) for telecommunications.
d. EMPLOYMENT SUPPORTS

i. Definition of Service

Employment Support Services: Employment support services provide support to the member in achieving and maintaining employment in jobs of his or her choice in his or her community. Employment supports include job development and job coaching supports after available vocational rehabilitation supports have been exhausted.

Employment supports will be provided by staff at current or potential work sites. When supported employment 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.

Providers will maintain a confidential case file for each individual that documents activities, progress and scope of work outlined in the member’s SDCB care plan. Documentation is maintained in the file of each member receiving this service to demonstrate that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or IDEA.

Employment supports include the following services:

a. **Job Coaching**: Job coaching is a service provided to members when the services are not otherwise available for the member under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation or through the New Mexico Department of Education. Job coaching services are available 365 days a year, 24 hours a day. Services are driven by the member’s SDCB care plan and job. Medicaid funds are not used to pay the member. Job coaches will adhere to the specific supports and expectations negotiated with the member and employer prior to service delivery.

b. **Job Development**: Job development services are provided to members when the services are not otherwise available for the member under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation or through the New Mexico Department of Education. Job development is a service provided to members by skilled staff. The service has five components: job identification and development activities; employer negotiations; job restructuring; job sampling; and job placement.

ii. Scope of Job Coach Services:

Job coach services will include, but are not limited to the following:
a. Provide support to members as contained in the SDCB care plan as to achieve his or her outcomes;

b. Teach vocational skills in a workplace setting;
c. Employ job-coaching techniques and help members learn to accomplish job tasks to the employer’s specifications;
d. Increase the member’s capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
e. Identify and strengthen natural supports that are available to the member at the job site and decrease paid supports in response to increased natural supports;
f. Identify specific information about the member’s interests, preferences and abilities;
g. Effectively communicate with the employer about how to support the member to succeed including any special precautions and considerations of the member’s disability, medications, or other special concerns;
h. Monitor and evaluate the effectiveness of the service and provide reports or documentation to the member as requested in the SDCB care plan;
i. Address behavioral, medical or other significant needs identified in the SDCB care plan;
j. Follow any individual specific therapeutic recommendations including speech, occupational and/or physical therapy, behavioral support, special diets and other therapeutic routines that are noted in the SDCB care plan;
k. Communicate effectively with the member including communication through the use of adaptive equipment as well as the member’s communication dictionary, if applicable, at the work site;
l. Monitor the health and safety of the member;
m. Model behavior, instruct and monitor any work place requirements to the member;
n. Adhere to professionally acceptable business attire and appearance, and communicate professionally and in a respectful manner; and
o. Adherence to rules of the specific work place, including dress, confidentiality, safety rules and other areas required by the employer.

iii. Scope of Job Development Services:

a. Identify potential employers and jobs in the area that provide work opportunities consistent with the member’s preferences, interests and choice;
b. Negotiate job functions, hours and supervision in the member’s best interest;
c. Conduct satisfaction surveys as requested by the member;
d. Broker relationships between the employer and the member in order to develop and maintain job success;
e. Identify potential employers and jobs in the area that provide work opportunities consistent with the member’s preferences, interests and choices;
f. Conduct job task analysis to ensure appropriate job match(es);
g. Assess barriers to member skill development on the job and provide or obtain appropriate accommodations tailored to the member’s ability to master task;

h. Interact professionally in individual and group contacts, on the phone, in writing with various levels of the company, including human resources and management;

i. Assist the employer with Americans with Disabilities Act (ADA) issues, Work Opportunity Tax Credit (WOTC) eligibility, requests for reasonable accommodations, disability awareness training and workplace modification or make referrals to appropriate agencies;

j. Utilize, refer and communicate with the Division of Vocational Rehabilitation (DVR) concerning job placement and referral activities consistent with industry and SDCB standards;

k. Utilize Department of Labor Navigators, One-Stop Career Centers, Department of Labor, Business Leadership Network, Chamber of Commerce, Job Accommodation Network, Small Business Development Centers, Retired Executive, Businesses, community agencies, and the NM Employment Institute to achieve employment outcomes;

l. Maintain on-going communication with various levels of the employer company to assure satisfaction to both the member and the company;

m. During the time of service delivery, ensure the member’s earnings and benefits are in accordance with Fair Labor Standards Act. Each member’s earnings and benefits will be reviewed at least semi-annually during the SDCB care plan year to ensure the appropriateness of pay rates and benefits;

n. Conduct a vocational assessment or profile as deemed necessary upon request of the member;

o. Provide a career development plan as deemed necessary or upon the request of the member;

p. Develop specific supports and expectations at the work site that are appropriate to the setting and negotiated with the employer prior to and during employment;

q. Verify and ensure that members receive job benefits and services such as paid time off, health insurance, retirement, awards, raises, performance reviews and training consistent with those in a similar job category; and

r. Provide career and skill development for advancement and integration in work-related activities or events.

iv. Job Coach Qualifications – Individual Provider:

a. Be at least 18 years of age;

b. Be qualified to perform the service and demonstrate capacity to perform required tasks;

c. Be able to communicate successfully with the member;

d. Experience as a job coach for at least (1) one year;

e. Experience for at least (1) one year using job and task analyses;
f. Trained on American with Disabilities Act (ADA);
g. Trained on the purpose, function and general practices of the Division of Vocational Rehabilitation (DVR);
h. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
i. Complete training on critical incident, abuse, neglect, and exploitation reporting;
j. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and
k. Meet any other service qualifications, as specified in the SDCB rules.

v. Job Developer Qualifications – Individual Provider:
   a. Be at least 18 years of age;
   b. Pass criminal background check and abuse registry screen;
   c. Experience as a job developer for at least (1) one year;
   d. Experience for at least (1) one year developing and using job task and analyses;
   e. Experience for at least (1) one year working with the Division of Vocational Rehabilitation, an independent living center or organization that provides employment supports or services for people with disabilities;
   f. Trained on the purposes, functions and general practices entities such as:
      1. Department of Workforce Solutions Navigators;
      2. One-Stop Career Centers;
      3. Business Leadership Network;
      4. Chamber of Commerce;
      5. Job Accommodation Network;
      6. Small Business Development Centers;
      7. Retired Executives; and
   g. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
   h. Complete training on critical incident, abuse, neglect, and exploitation reporting;
   i. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and
   j. Meet any other service qualifications, as specified in the SDCB rules.
vi. **Job Coach and/or Job Developer Qualifications – Provider Agency:**

a. Possess a current business license, if applicable;

b. Meet financial solvency;

c. Adhere to training requirements;

d. Maintain individual records for each member within HIPAA compliance. The agency will maintain a confidential case file for each member that documents activities, progress and scope of work outlined in the member’s SDCB care plan;

e. Develop and adhere to a records management policy; and

f. Develop and adhere to quality assurance rules and requirements.

g. Ensure job coaches have the following qualifications:

1. Be at least 18 years of age;

2. Be qualified to perform the service and demonstrate capacity to perform required tasks;

3. Be able to communicate successfully with the member;

4. Experience as a job coach for at least one year;

5. Experience for at least one year using job and task analyses;

6. Trained on American with Disabilities Act (ADA);

7. Trained on the purpose, function and general practices of the Division of Vocational Rehabilitation (DVR);

8. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

9. Complete training on critical incident, abuse, neglect, and exploitation reporting;

10. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and

11. Meet any other service qualifications, as specified in the SDCB rules.

h. Ensure job developers have the following qualifications:

1. Be at least 18 years of age;

2. Experience as a job developer for at least (1) one year;

3. Experience for at least (1) one year developing and using job task and analyses;

4. Experience for at least (1) one year working with the Division of Vocational Rehabilitation, an independent living center or organization that provides employment supports or services for people with disabilities;

5. Trained on the purposes, functions and general practices entities such as:

a) Department of Workforce Solutions Navigators;

b) One-Stop Career Centers;

c) Business Leadership Network;
d) Chamber of Commerce;
e) Job Accommodation Network;
f) Small Business Development Centers;
g) Retired Executives; and
h) New Mexico employment institute.

6. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

7. Complete training on critical incident, abuse, neglect, and exploitation reporting;

8. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and

9. Meet any other service qualifications, as specified in the SDCB rules.
e. ENVIRONMENTAL MODIFICATION

i. Definition of Service

Environmental modification services include the purchase and/or installation of equipment and/or making physical adaptations to a member's residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member’s level of independence. All services shall be provided in accordance with applicable federal, state, and local building codes. Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member, such as fences, storage sheds or other outbuildings. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.

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, waiver providers and contractors concerning environmental modification projects to the member's residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted 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.

Environmental modification services are limited to five thousand dollars ($5,000.00) every five (5) years.

Environmental modifications will not be reimbursed from related goods.

ii. Scope of Services:

Environmental Adaptations include the following:

a. Installation of ramps and grab-bars;
b. Widening of doorways/hallways;
c. Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
d. Installation of lifts/elevators;
e. Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);
f. Turnaround space adaptations;
g. Installation of specialized accessibility/safety adaptations/additions;
h. Installation of Trapeze and mobility tracks for home ceilings;
i. Installation of Automatic door openers/doorbells;
j. Installation of Voice-activated, light-activated, motion-activated and electronic devices;
k. Installation of Fire safety adaptations;
l. Installation of Air filtering devices;
m. Installation of heating/cooling adaptations;
n. Installation of glass substitute for windows and doors;
o. Installation of modified switches, outlets or environmental controls for home devices; and
p. Installation of alarm and alert systems and/or signaling devices.

iii. Environmental Modification Qualifications – Individual Contractor and Agency Contractor:
   a. Current business license;
   b. Appropriate plumbing, electrician, contractor license; and/or
   c. Appropriate technical certification or other license to perform the modification.
f. HOME HEALTH AIDE

i. Definition of Service

Home health aide services provide total care or assist a member in all activities of daily living. Home health aide services assist the member in a manner that will promote and improve the member’s quality of life and provide a safe environment for the member. Home health aide services can be provided outside the 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.

ii. Scope of Services:

a. Provide personal hygiene (e.g. sponge bathing, showering, bed shampooing, shaving, oral hygiene dressing);

b. While under the supervision of a licensed physical therapist or licensed nurse (RN or LPN), assist with ambulation, transfer and range of motion exercises;

c. Assist with menu planning, meal/snack preparation and assist member with eating as necessary;

d. As ordered by a physician and under supervision of a licensed nurse (RN or LPN), he/she will assist with bowel and bladder elimination with activities such as: catheter care, colostomy care, enemas, insertion of non-prescribed suppository, prosthesis care and vital signs;

e. Provide homemaking services (e.g. laundry, linen change, cleaning);

f. Pick up medication(s);

g. Assist or prompt member in self administration of medication(s);

h. Observe general condition of member and report changes to supervisor;

i. Document member’s status and services furnished, infection control procedures; and

j. Recognize emergencies and adhere to emergency procedures.

iii. Home Health Aide Qualifications – Agency Provider:

a. Licensed in New Mexico as a home health agency, rural health clinic or federally qualified health center;

b. Possess current business license;

c. Meet financial solvency;

d. Adhere to training requirements;

e. Maintain individual records for each member within HIPAA compliance;
f. Develop and adhere to a records management policy;
g. Develop and adhere to quality assurance policies and processes; and
h. Supervision must be performed by a registered nurse. Such supervision must occur at least once every 60 calendar days in the member's home, and shall be in accordance with the New Mexico Nurse Practice Act and be specific to the member's SDCB care plan. Contact must be made with family members during supervision.
i. Ensure all assigned staff meet the following qualifications:
   1. Be at least 18 years of age;
   2. Be qualified to perform the service and demonstrate capacity to perform required tasks;
   3. Have successfully completed a home health aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a home health aide training program pursuant to 7.28.2.30 NMAC. Copies of Certified Nurse Aide (CNA) certificates must be maintained in the personnel file of the home health aide;
   4. Be able to communicate successfully with the member;
   5. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
   6. Complete training on critical incident, abuse, neglect, and exploitation reporting; and
   7. Meet any other service qualifications, as specified in the SDCB rules.
g. HOMEMAKER/DIRECT SUPPORT

i. Definition of Service
Homemaker or direct support services are provided on an episodic or continuing basis to assist the 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 members needs. The member identifies the homemaker or direct support worker’s training needs. If the member is unable to do the training him/her self, the member arranges for the needed training.

Providers will bill for services in shared households within state guidelines. Two (2) or more 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.

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 waiver members under age 21.

ii. Scope of Services:
Homemaker/Direct Support Services include but are not limited to the following:

a. Assist the member with activities of daily living;

b. Perform general household tasks;

c. Provide companionship to acquire, maintain or improve social interaction skills in the community; and

d. Attend trainings as designated by the member in the SDCB care plan.

iii. Homemaker/Direct Support Qualifications – Individual Provider:

a. Be at least 18 years of age;

b. Be qualified to perform the service and demonstrate capacity to perform required tasks;

c. Be able to communicate successfully with the member;

d. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

e. Complete training on critical incident, abuse, neglect, and exploitation reporting;

f. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training
expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and

g. Meet any other service qualifications, as specified in the SDCB rules.

iv. Homemaker/Direct Support Qualifications – Agency Provider:
   a. Home health agencies must hold a home health agency license;
   b. Possess a current business license, if applicable;
   c. Meet financial solvency;
   d. Adhere to training requirements;
   e. Maintain individual records for each member within HIPAA compliance;
   f. Develop and adhere to a records management policy; and
   g. Develop and adhere to quality assurance rules and requirements.
   h. Ensure all assigned staff meet the following qualifications:
      1. Be at least 18 years of age;
      2. Be qualified to perform the service and demonstrate capacity to perform required
tasks;
      3. Be able to communicate successfully with the member;
      4. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978,
         Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to
         NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
      5. Complete training on critical incident, abuse, neglect, and exploitation reporting;
      6. Complete member specific training; the evaluation of training needs is determined
         by the member or his/her legal representative; member is also responsible for
         providing and arranging for employee training and supervising employee
         performance; training expenses for paid employees cannot be paid for with the
         SDCB member’s annual budget; and
      7. Meet any other service qualifications, as specified in the SDCB rules.
h. NUTRITIONAL COUNSELING

i. Definition of Service
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.

ii. Scope of Services:
   a. Assessment of nutritional needs;
   b. Development and/or revision of the member’s nutritional plan; and
   c. Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

iii. Nutritional Counseling Qualifications - Individual Provider:
   Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et.seq.

iv. Nutritional Counseling Qualifications - Agency Provider:
   a. Current business license; and provide a tax identification number;
   b. Ensure staff meet the following qualifications:
   c. Licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et.seq.
i. PRIVATE DUTY NURSING FOR ADULTS

i. Definition of Service
Private Duty Nursing for Adults services includes activities, procedures, and treatment for a member’s physical condition, physical illness or chronic disability.

ii. Scope of Services:
Private duty nursing services for adults may include performance, assistance and education with the following tasks:

a. Medication management, administration and teaching;
b. Aspiration precautions;
c. Feeding tube management, gastrostomy and jejunostomy;
d. Skin care;
e. Weight management;
f. Urinary catheter management;
g. Bowel and bladder care;
h. Wound care;
i. Health education and screening;
j. Infection control;
k. Environmental management for safety;
l. Nutrition management;
m. Oxygen management;
n. Seizure management and precautions;
o. Anxiety reduction;
p. Staff supervision; and
q. Behavior and self-care assistance.

iii. Private Duty Nursing Qualifications - Agency Provider:

a. Licensed in New Mexico as a Home Health Agency, Rural Health Clinic or federally Qualified Health Center (FQHC Agency);
b. Possess current business license;
c. Meet financial solvency;
d. Adhere to training requirements;
e. Maintain individual records for each member within HIPAA compliance;
f. Develop and adhere to a records management policy; and
  
g. Develop and adhere to quality assurance policies and processes.

h. Ensure all assigned staff meet the following qualifications:

1. Licensed by the New Mexico State Board of Nursing as a RN or LPN;
2. Demonstrate capacity to perform required tasks;
3. Be able to communicate successfully with the member;
4. Complete training on critical incident, abuse, neglect, and exploitation reporting;
5. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN; and
6. Meet any other service qualifications, as specified in the SDCB rules.

iv. Private Duty Nursing Qualifications - Individual Provider:
   a. Provide a tax identification number;
   b. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN;
   c. Demonstrate capacity to perform required tasks;
   d. Be able to communicate successfully with the member;
   e. Complete training on critical incident, abuse, neglect, and exploitation reporting; and
   f. Meet any other service qualifications, as specified in the SDCB rules.
j. RELATED GOODS

i. Definition of Service
Related goods are equipment, supplies, fees (such as for conferences or classes) or memberships, not otherwise provided through SDCB, the Medicaid state plan or through Medicare. Related goods do not include services; examples of such services include life skills coach, housecleaning, yard maintenance, etc.

ii. Scope of Services:
Related goods must address a need identified in the member’s SDCB care plan (including improving and maintaining the member’s opportunities for full membership in the community) and meet the following requirements:

a. Be responsive to the member’s qualifying condition or disability; and
b. Meet the member’s clinical, functional, medical or habilitative needs; and
c. Support the member to remain in the community and reduces the risk for institutionalization; and
d. Promote personal safety and health; and afford the member an accommodation for greater independence; and
e. Decrease the need for other Medicaid services; and
f. Accommodate the member in managing his/her household; or
g. Facilitate activities of daily living.
h. Related goods must be documented in the SDCB care plan, and be approved by the MCO/UR. The cost and type of related good is subject to approval by the MCO/UR. 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 member to find other (including less costly) alternatives.

i. The related goods must not be available through another source and the member must not have the personal funds needed to purchase the goods.
j. Experimental or prohibited treatments and goods are excluded.

iii. Related Goods Qualifications - Vendor Agency Provider:
Valid tax identification for the state and federal governments.
k. RESPITE

i. Definition of Service
Respite is a flexible family support service that provides support to the member and gives the primary unpaid caregiver time away from his/her duties. Respite services are furnished on a short term basis and can be provided in the 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.

ii. Scope of Services:
Respite services include, but are not limited to the following:

a. Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary unpaid provider. Additional hours may be requested if an eligible beneficiary’s health and safety needs exceed the specified limit.
b. Assist with routine activities of daily living (e.g. bathing, toileting, preparing or assisting with meal preparation and eating);
c. Enhance self-help skills, leisure time skills and community and social awareness;
d. Provide opportunities for leisure, play and other recreational activities;
e. Provide opportunities for community and neighborhood integration and involvement;
f. Provide opportunities for the member to make his/her own choices with regards to daily activities.
g. Respite services do not include the cost of room and board;
h. Cannot be used for purposes of day-care; and
i. Cannot be provided to school age children during school hours.

iii. Respite Qualifications – Individual Provider:

a. Be at least 18 years of age;
b. Be qualified to perform the service and demonstrate capacity to perform required tasks;
c. Be able to communicate successfully with the member;
d. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
e. Complete training on critical incident, abuse, neglect, and exploitation reporting;
f. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training
expenses for paid providers cannot be paid for with the SDCB member’s annual budget;
g. Meet any other service qualifications, as specified in the SDCB rules; and
h. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN.

iv. Respite Qualifications - Provider Agency:
   a. Possess a current business license, if applicable;
b. Meet financial solvency;
c. Adhere to training requirements;
d. Maintain individual records for each member within HIPAA compliance;
e. Develop and adhere to a records management policy; and
f. Develop and adhere to quality assurance rules and requirements.
g. Ensure all assigned staff meet the following qualifications:
   1. Be at least 18 years of age;
   2. Be qualified to perform the service and demonstrate capacity to perform required tasks;
   3. Be able to communicate successfully with the member;
   4. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
   5. Complete training on critical incident, abuse, neglect, and exploitation reporting;
   6. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget;
   7. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN; and
   8. Meet any other service qualifications, as specified in the SDCB rules.
1. **SKILLED MAINTENANCE THERAPIES SERVICES**

   i. **Definition of Service**

      a. **Therapies:** 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. 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.

      1. **Physical therapy:** Physical therapy is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities.
      2. **Occupational therapy:** 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.
      3. **Speech language therapy:** 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 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.
      4. A signed therapy referral for treatment must be obtained from the member’s primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered.

   ii. **Scope of Services:**

      a. **Physical therapy:**

      1. Diagnostic activities to determine the dysfunction of physical and functional activities;
      2. Activities to increase, maintain or reduce the loss of functional skills;
      3. Treat specific condition(s) clinically related an member’s qualifying condition or disability;
      4. Activities to support the member’s health and safety needs; and
      5. Identify, implement and train on therapeutic strategies to support the member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.
b. Occupational therapy:

1. Diagnostic activities to determine skills assessment and treatment;
2. Write treatment program to improve one’s ability to perform daily tasks;
3. Comprehensive home, employment and/or volunteer sites evaluations with adaptation recommendations;
4. Provide guidance to family members and caregivers;
5. Make assistive technology recommendations and provide usage training for members, family and staff; and
6. Identify, implement and train on therapeutic strategies to support the member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.

c. Speech and language pathology:

1. Improve or maintain the member’s capacity for successful communication or to lessen the effects of the member’s loss of communication skills;
2. Consultation on usage and training on augmentative communication devices;
3. Activities to improve or maintain the member’s ability to eat food, drink liquid and manage oral secretions with minimal risk of aspiration or other injuries or illness related to swallowing disorders; and
4. Activities to identify, implement, and train on therapeutic strategies to support the member, his/her family and/or staff consistent with the member’s SDCB care plan.

iii. Therapy Qualifications – Individual Therapist Provider:

a. Provide a tax identification number.

b. Maintain a case file within HIPAA guidelines for the member to include:
   1. Member’s SDCB care plan;
   2. Reports as requested in the SDCB care plan;
   3. Contact notes;
   4. Training roster(s); and
   5. Assessments for environmental modification requests.

c. Licensures:
   6. Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq.;
   7. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; and
   8. Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B-1et.seq.
iv. Therapy Qualifications – Provider Agency:
   a. Current business license;
   b. Provide tax identification number;
   c. Ensure physical therapists maintain a case file within HIPAA guidelines for the member to include:
      1. Member’s SDCB care plan;
      2. Reports as requested in the SDCB care plan;
      3. Contact notes;
      4. Training roster(s); and
      5. Assessments for environmental modification requests.
   d. Ensure therapists has appropriate license for service:
      1. Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq.;
      2. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; and
      3. Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B-1et.seq.
m. Specialized Therapies Services:

i. Definition of Service
Specialized therapies are non-experimental therapies or techniques that have been proven effective for certain conditions. Services must be related to the person’s disability or condition, and ensure the member’s health and welfare in the community. The service will supplement (not replace) the member’s natural supports and other community services for which the 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.

ii. Scope of Services:
   a. Acupuncture is a distinct system of primary health care. The goal of acupuncture is to prevent, cure or correct any disease, illness, injury, pain or other physical or mental condition by controlling and regulating the flow and balance of energy, form and function to restore and maintain physical health and increased mental clarity. Acupuncture may provide effective pain control, decreased symptoms of stress, improved circulation and a stronger immune system, as well as other benefits. See Acupuncture and Oriental Medicine Practitioners 16.2.1 NMAC.
   b. Biofeedback uses visual, auditory or other monitors to provide members physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral and cognitive health performance. Biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness.
   c. Chiropractic care is designed to locate and remove interference with the transmissions or expression of nerve forces in the human body by the correction of misalignments or subluxations of the vertebral column and pelvis. Chiropractic care restores and maintains health for treatment of human disease primarily by, but not limited to adjustment and manipulation of the human structure. Chiropractic therapy may positively affect neurological function, improve certain reflexes and sensations, and increase range of motion and lead to improved general health. See Chiropractor 16.4.1 NMAC.
   d. Cognitive rehabilitation therapy is designed to improve cognitive functioning with the following activities: reinforcing, strengthening, or re-establishing previously learned patterns of behavior; establishing new patterns of cognitive activity; or compensatory mechanisms of impaired neurological systems. Treatments may be focused on improving a particular cognitive domain such as attention, memory,
language, or executive functions. Alternatively, treatments may be skill-based, aimed at improving performance of activities of daily living. The overall goal is to restore function in a cognitive domain or set of domains or to teach compensatory strategies to overcome specific cognitive problems.

e. **Hippotherapy** is a physical, occupational and speech-language therapy treatment strategy that utilizes equine movement as part of an integrated intervention program to achieve functional outcomes. Hippotherapy applies multidimensional movement of a horse for members with movement dysfunction and may increase mobility and range of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the member use cognitive functioning especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production.

f. **Massage therapy** is the assessment and treatment of soft tissues and their dysfunction for therapeutic purposes primarily for comfort and relief of pain. It includes gliding, kneading, percussion, compression, vibration, friction, nerve strokes, stretching the tissue and exercising range of motion and may include the use of oils, salt glows, hot or cold packs or hydrotherapy. Massage increases the circulation, helps loosen contracted, shortened muscles and can stimulate weak muscles to improve posture and movement, improves range of motion and reduces spasticity. Massage therapy may increase, or help sustain, a member’s ability to be more independent in the performance of activities of daily living; thereby, decreasing dependency upon others to perform or assist with basic daily activities. See Massage Therapists 16.7.1 NMAC.

g. **Naprapathy** focuses on the evaluation and treatment of neuro-musculoskeletal conditions and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and joints and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See Naprapathic Practitioners 16.6.1 NMAC.

h. **Native American healing therapies** encompass a wide variety of culturally-appropriate therapies that support members in their communities by addressing their physical, emotional and spiritual health. Treatments may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects.
iii. Specialized Therapy Qualifications – Individual Therapist Provider
a. Current New Mexico state license as applicable:

1. Acupuncture and Oriental Medicine license
2. Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
3. Chiropractic Physician license
4. Cognitive rehabilitation therapy – license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision.
5. Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy and appropriate specialized training and experience.
6. Massage therapy license
7. Naprapathic Physician license
8. Native American Healers – individuals who are recognized as healers within their communities. This form of therapy may be provided by community-recognized medicine men and women and others as healers, mentors and advisors to members.

iv. Specialized Therapy Qualifications - Provider Agency:

a. Current business license; and
b. Provide tax identification number;
c. Group practice/vendor staff must hold current New Mexico licensure and training in their respective discipline as follows:

1. Acupuncture and Oriental Medicine license
2. Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
3. Chiropractic Physician license
4. Cognitive rehabilitation therapy – license in a health care profession whose scope of practice includes cognitive rehabilitation therapy, and appropriate specialized training and clinical experience and supervision.
5. Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy and appropriate specialized training and experience.
6. Massage therapy license
7. Naprapathic Physician license
8. Native American Healers – individuals who are recognized as healers within their communities.
n. TRANSPORTATION

i. Definition of Service
Transportation services are offered in order to enable members to gain access to SDCB and other community services, activities and resources, as specified by the SDCB care plan. 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 vacation is not covered through the SDCB Program.

Transportation is reimbursed in several 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. Payments are made to the member’s individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the member. Whenever possible, natural supports should provide this service without charge.

ii. Scope of Services:
   a. The service will be provided as specified in the member’s SDCB care plan and budget.
   b. SDCB transportation services cannot be used instead of or to replace transportation services available under the Medicaid state plan.

iii. Transportation Qualifications - Individual Provider:
   a. Be at least 18 years of age;
   b. Possess a valid New Mexico drivers license;
   c. Be free of physical or mental impairment that would adversely affect driving performance;
   d. No driving while intoxicated (DWI) convictions within the previous two (2) years;
   e. No chargeable (at fault) accidents within the previous two (2) years;
   f. Have current CPR/First Aid certification;
   g. Complete training on critical incident, abuse, neglect, and exploitation reporting; and
   h. Possess and maintain current insurance policy and registration.

iv. Transportation Qualifications – Provider Agency:
   a. Current business license;
   b. Valid tax identification number;
   c. Have a current basic First Aid kit in the vehicle;
   d. Each vehicle will contain a current insurance policy and registration; and
   e. Ensure drivers meet individual qualifications:
      1. Be at least 18 years of age;
      2. Possess a valid New Mexico drivers license;
3. Be free of physical or mental impairment that would adversely affect driving performance;
4. No driving while intoxicated (DWI) convictions within the previous two (2) years;
5. No chargeable (at fault) accidents within the previous two (2) years;
6. Have current CPR/First Aid certification;
7. Complete training on critical incident, abuse, neglect, and exploitation reporting;
8. Trained on New Mexico Department of Health Improvement (DHI) Critical Incident Reporting and Procedures; and
9. Possess current insurance policy and registration.
12. SELF-DIRECTED NON-COVERED SERVICES

All SDCB services are subject to the approval of the MCO/UR.

When a SDCB member requests a non-covered service or good, the support broker and/or care coordinator shall work with the member to find other (including less costly) alternatives.

Services and goods that are not covered by the SDCB program include, but are not limited to the following:

a. Services covered by third-parties. The SDCB Program is the payer of last resort;

b. Any service or good, the provision of which would violate federal or state statutes, rules or guidance. This includes services that are considered primarily recreational or diversional, which are not deemed eligible SDCB services by CMS;

c. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the Division of Vocational Rehabilitation (DVR);

d. Room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses. Utilities include gas, electricity, propane, fire wood, wood pellets, water, sewer, and waste management;

e. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;

f. Any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;

g. Any goods or services that are to be used for recreational or diversional purposes;

h. Personal goods or items not related to the SDCB member’s condition or disability;

i. Purchase of animals and the costs of maintaining animals, including the purchase of food, veterinary visits, grooming and boarding but with the exception of training and certification for service dogs;

j. Gas cards and gift cards. Items that are purchased with SDCB program funds may not be returned for cash or gift cards;

k. Purchase of insurance, such as car, health, life, burial, renters, home-owners, service warrantees or other such policies. This includes purchase of cell phone insurance;

l. Purchase of a vehicle, and long-term lease or rental of a vehicle;

m. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;

n. Firearms, ammunition or any other type of weapons;

o. Gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;

p. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses. This also includes mileage or driver time reimbursement for vacation travel by automobile;
q. Purchase of usual and customary furniture and home furnishings, unless adapted to the SDCB member’s disability or use, or of specialized benefit to the SDCB member’s condition. Requests for adapted or specialized furniture or furnishings must include a doctor’s order from the member’s health care provider and, when appropriate, a denial of payment from any other source;

r. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the SDCB member’s qualifying condition or disability;

s. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member’s qualifying condition or disability. Requests must include documentation that the adapted vehicle is the SDCB member’s primary means of transportation;

t. Clothing and accessories, except specialized clothing based on the SDCB member’s disability or condition;

u. Training expenses for paid employees;

v. Conference or class fees may be covered for SDCB members or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging or meals;

w. For consumer electronics such as computers, printers and fax machines, or other electronic equipment, no more than one (1) of each type of item may be purchased at one (1) time, and consumer electronics may not be replaced more frequently than once every three (3) years. Laptops or any electronic tablets are considered computers;

x. Cell phone services that include fees for data (to include GPS) or more than one (1) cell phone per SDCB member. SDCB may cover the cost of text messaging if it is documented and determined that the need for texting is related to the SDCB member’s disability; and

y. Moving expenses to include, but limited to, the cost of moving truck rental, gas/mileage, labor, moving equipment, supplies, boxes, tape and moving blankets.

13. SDCB Budget and Care Plan Approval Processes

a. Initial SDCB Budget Approval Process

The SDCB budget is determined by the care coordinator and is based on two factors: the needs identified in the CNA and the amount and type of services the member has been receiving in ABCB. The care coordinator shall review the existing ABCB services and calculate a dollar amount for the services, using the Medicaid-approved rate schedule. The care coordinator shall also review the needs identified in the CNA. Both of these evaluations are used to assign the SDCB budget amount to be used to develop the SDCB care plan. The care coordinator shall provide the support broker with the SDCB budget
amount. The initial SDCB budget shall be pro-rated based on the number of months already spent in the ABCB. The member must receive their services in the ABCB for 120 calendar days before transferring to the SDCB. The pro-rated budget is based on this initial period in the ABCB.

b. Initial SDCB Care Plan Approval Process
Once the SDCB care plan is developed, the support broker, in cooperation with the SDCB member, shall forward the SDCB care plan request to the MCO/UR for review and approval. The member’s SDCB care plan request must be approved by the MCO/UR before any SDCB services may begin.

The MCO/UR may make a request for (additional) information (RFI) from the SDCB/member during the process of reviewing the SDCB care plan. The support broker/care coordinator may assist the SDCB member in obtaining requested documents and responding to the RFI, but providing a timely and complete response to the MCO/UR is the SDCB member’s responsibility. If information is not received within 15 calendar days from the date of the RFI letter, the service or good will be denied.

The MCO/UR will notify the SDCB member and care coordinator/support broker in writing when a determination has been made on the SDCB care plan/budget request. The determination may be a full approval, a partial approval, or a denial. The MCO/UR shall indicate which goal(s) of the SDCB care plan/budget have been approved or denied in FOCoSonline. Written notifications will include steps to follow if the member disagrees with the decision.

The FMA will utilize the authorized budget to process payment for SDCB services and goods in the approved amount.

The SDCB member’s SDCB care plan/budget must be approved before SDCB services can begin. SDCB will not pay for any services, supports and/or goods provided or purchased prior to the approval of the SDCB care plan/budget.

c. Annual SDCB Budget Approval Process
Approximately calendar 90 days prior to the expiration of the existing SDCB care plan/budget, the Care Coordinator shall conduct the annual CNA. The Care Coordinator shall assign the SDCB budget based on the assessed needs identified in the CNA. The SDCB budget is determined annually and the budget amount may differ from year to year.

d. Annual SDCB Care Plan Approval Process
At a minimum, the SDCB care plan/budget must be developed and submitted to the MCO/UR for review, annually and no less than 30 calendar days prior to the expiration of
the existing SDCB care plan/budget. This timeframe allows enough time for the MCO/UR to make a determination before the existing care plan expires. The MCO/UR will notify the SDCB member and care coordinator/support broker in writing when a determination has been made on the SDCB care plan/budget request. The determination may be a full approval, a partial approval, or a denial. The MCO/UR shall indicate which goal(s) of the SDCB care plan/budget have been approved or denied in FOCoSonline. Written notifications will include steps to follow if the member disagrees with the decision.

14. Denials, Modifications, and Reconsiderations of the SDCB Care Plan

a. Denials

The MCO/UR shall send final decisions to the SDCB member in writing, including steps to follow if he/she disagrees with the decision and wants to pursue a reconsideration and/or the MCO appeal process. The MCO appeal process must be exhausted prior to the member requesting a State fair hearing.

b. Modifications

The SDCB care plan may be modified based upon a change in the member’s needs or circumstances identified in the CNA, such as a change in the member’s health status or condition, or a change in the member’s support system such as the death or disabling condition of a family member or other individual who was providing services.

If the modification is to provide new or additional services than originally included in the SDCB care plan, these services must not be able to be acquired through other programs or sources. The SDCB member may be required to document the fact that the services are not available through another source. The care coordinator/support broker shall assist the SDCB member with exploring other available resources.

The member must provide written documentation of the change in needs or circumstances as specified in the SDCB Policy Manual. The SDCB member submits the documentation to the care coordinator/support broker. The support broker initiates the process to modify the SDCB care plan by forwarding the request for a SDCB care plan revision to the MCO/UR for review, via FOCoSonline. Per the SDCB rule and at the MCO’s discretion, another CNA may be performed, particularly if additional services are needed which necessitates an increase to the budget.

The SDCB care plan may be modified once the original SDCB care plan has been submitted and approved. Only one (1) SDCB care plan revision may be submitted at a time, for example, a SDCB care plan revision may not be submitted if an initial SDCB care plan request or prior SDCB care plan revision request is under initial review by the
MCO/UR. This requirement also applies to any reconsideration of the same revision request.

Other than for critical health and safety reasons, SDCB care plan revision requests may not be submitted to the MCO/UR within the last 60 calendar days prior to the expiration date of the current SDCB care plan/budget.

c. Reconsiderations

If the SDCB care plan, or a part of the SDCB care plan, is not approved, the care coordinator/support broker assists the SDCB member to explore his/her options, including the right to request a reconsideration of the decision. Reconsideration requests must be submitted to the MCO/UR within 30-calendar days of the date on the denial notice. Reconsideration requests must be made by the support broker in writing and provide additional documentation or clarifying information regarding the SDCB member’s request for reconsideration of the denied services or goods.

15. SDCB Care Plan Review Criteria

Services and related goods identified in the SDCB member’s requested SDCB care plan may be considered for approval if all the following requirements are met:

a. The services or goods must be responsive and directly related to the SDCB member’s qualifying condition or disability; and
b. The services or goods must address the SDCB member’s clinical, functional, medical or habilitative needs; and
c. The services or goods must accommodate the SDCB member in managing his/her household; and
d. The services or goods must facilitate activities of daily living; and
e. The services or goods must promote the SDCB member’s personal health and safety; and
f. The services or goods must afford the SDCB member an accommodation for greater independence; and
g. The services or goods must support the SDCB member to remain in the community and reduce his/her risk for institutionalization; and
h. The services or goods must be documented in the SDCB care plan and facilitate the desired outcomes in the SDCB member’s SDCB care plan/budget; and
i. The service or good is not prohibited by federal and state statutes, rules and guidance; and
j. Each service or good must be listed as an individual line item; when services or goods must be ‘bundled’ the SDCB care plan must document why bundling is necessary and appropriate; and
k. The proposed annual budget request is within the SDCB member’s authorized budget; and
1. The proposed rate for each service is within the SDCB range of rates (Appendix C) for that chosen service; and
m. The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
n. The estimated cost of the service or good is specifically documented in the SDCB member’s SDCB care plan/budget.

16. Implementation of the SDCB Care Plan/Budget

a. Enrolling Employees and Vendors
   i. Pre Hire Packet
   Before providing services to a SDCB member, most employees and vendors must submit the appropriate state approved pre-hire packet to the FMA and pass the COR screening. The exception to this requirement is when the vendor has a professional license, such as a registered nurse or SLP that qualifies them to provide the approved service. The FMA is responsible for maintaining, distributing and processing the pre-hire packets. For answers to questions about hiring employees or vendors and to obtain the pre-hire packet, an EOR shall contact the FMA Help Desk at 1-866-916-0310.

   Potential employees are required by NM law through the caregivers’ criminal history screening act (7.1.9 NMAC) to pass a criminal background check (CBC) which must first be processed against the COR. This COR screening is completed by the FMA, usually within 48 hours, once the complete and correct pre-hire packet is received by the FMA. Once the COR check is completed, and the provider has passed the COR check, the EOR will receive an e-mail notification that the employee has passed their COR Background Check. If the EOR does not have an e-mail address listed in FOCoSonline, the SDCB Help Desk will contact the EOR, via telephone to let the EOR know that the employee has passed the COR check. Although an employee may begin providing services as soon as they have passed their COR Background Check, payment will not be issued until all required paperwork as indicated below is completed and has been approved by the FMA. If an employee or vendor does not pass the CBC, as required by NM law, he/she may not provide services to the SDCB member. The employee or vendor and FMA will be notified by the Department of Health if he/she does not pass the CBC. The FMA will notify the SDCB member/EOR when a potential employee has or has not successfully completed the COR check and/or CBC.

   No employee shall exceed 40 hours paid work in a consecutive seven (7) day period, per EOR. If an employee works for more than one EOR, the employee can work up to 40 hours per EOR in a consecutive seven (7) day period.
ii. Credentialing Requirements

The State has set credentialing requirements for credentialing providers of SDCB services, and these requirements have been approved by the Centers for Medicare and Medicaid Services (CMS). The FMA must ensure that these requirements are met. These requirements include certain licenses which must be submitted to the FMA, and are described in Appendix D & E (Vendor and Employee Credentialing Requirements).

iii. Other Required Documents

There are other documents that must be correctly completed by the employee or vendor and submitted to the FMA before payment can be made. These documents may be obtained by contacting the FMA at 1-866-916-0310.

- **For Employees,** the required documents are included in the Employee Packet:
  - i. Employment Agreement
  - ii. Employee Information Form
  - iii. Declaration of Relationship form
  - iv. Federal W-4
  - v. State W-4

- **For Vendors who are providing services** (for example: acupuncture), the required documents are included as part of the Vendor Packet:
  - i. Vendor Agreement
  - ii. Vendor Information Form
  - iii. Federal W-9

Vendors who are providing goods only (such as a large retailer) do not need to provide such documentation, however the member or vendor must submit the Vendor Information Form to the FMA before payment is issued.

Direct Deposit is provided and strongly recommended for all employees and vendors when possible. The FMA also offers the service of providing payment through a ComData Card. Please contact the FMA if interested in using this service. Direct deposit forms can be completed as part of the initial hire documentation, or may be completed and submitted to the FMA at a later date.

b. **Purchasing Services and Goods**

- **i. Timesheets**

  With access to the FOCoSonline system, an employee (or EOR) may enter the employee(s)’s timesheet(s) in FOCoSonline. The EOR may then review and approve the timesheet through their online access. Having access to FOCoSonline and submitting timesheets online means that the EOR or employees do not need to send the timesheet to the FMA for processing. Upon completing the FOCoSonline training, a new user will receive a FOCoSonline Account Authorization form (via e-
mail). Once the new user completes the FOCoSonline Account Authorization form and faxes it to the FMA Technical Department (1-866-648-7526), the user will receive an e-mail with his/her password and login instructions. Timesheets may also be mailed or faxed to the FMA (1-866-302-6787).

Timesheets are submitted and processed on a two-week pay schedule according to the SDCB Payroll Payment Schedule. The payroll workweek starts on Saturday and ends the following Friday. The payment schedule is available through FMA or on the MCOs’ websites. Timesheets are due at the end of the two-week pay period and must be received at the FMA no later than Saturday at 11:59 pm.

An Authorized Representative may also complete the training and gain access to FOCoSonline. If an AA has access, they will be able to view payments and monitor budget spending, however, they will not have authorization to perform the functions of the EOR and approve timesheets. To designate an AA, members must complete the AA Form, which may be requested through the FMA or the care coordinator/support broker.

ii. Invoices

Vendor Payment Request Forms (PRF) (Appendix F) and invoices may be submitted to the FMA on any day of the week (unlike timesheets which must be submitted according to the payroll schedule). The processing time for a PRF/invoice is approximately two (2) weeks. Please see the Vendor Payment Schedule for details, the vendor payment schedule may be found in the monthly SDCB newsletter that is mailed to members by the FMA. Vendor checks are mailed directly to the EOR (payments are not mailed to the vendor). After the EOR receives the vendor check, it is recommended that the EOR mail the check to the vendor as soon as possible to ensure prompt payment. For phone/internet payments, the EOR should send the payment to the phone/internet company’s main billing address (with the payment coupon). It is not recommended that phone/internet payments be attempted through kiosks or at local phone/internet stores (e.g., T-Mobile or Cricket) since these payments are frequently rejected by TeleCheck.

Although an EOR may submit timesheets online (after completing necessary FOCoSonline training and paperwork), it is not possible to submit invoices online. PRFs and invoices must be faxed to the FMA (1-866-302-6787) for processing. However, if a SDCB member/EOR has access to FOCoSonline, they may review their payments and monitor them as they are being processed. In addition, the SDCB member, EOR, or AA may run reports through FOCoSonline to monitor spending activity.
iii. Return to Member Process

Return-to-Member (RTM) letters are an effective means used by the FMA to assist in communicating with the EOR when there are problems in processing payment. For example, if a timesheet or invoice is submitted to the FMA and it does not contain the appropriate signatures, the FMA uses the RTM process as a means to inform the EOR that payment could not be made. In addition to the RTM letter which is mailed, the FMA attempts contact with the EOR by phone. If three (3) unsuccessful phone call attempts to the EOR have been made and the corrected document still has not been received, the FMA will send an e-mail to the EOR (provided the EOR has an e-mail address in FOCoSonline) with a copy to the care coordinator/support broker. If the EOR does not have an e-mail address in FOCoSonline, the FMA will send an e-mail to the care coordinator/support broker and attach a copy of the RTM letter. Since frequent contact is attempted by the FMA to the EOR, it is extremely important that FOCoSonline contain the EOR’s correct contact information. If the EOR contact information needs to be updated, please contact the FMA Help Desk (1-866-916-0310) for assistance.

iv. Employee and Vendor Pay Rates

Employee and vendor pay rates must be approved in the SDCB member’s SDCB care plan/budget. Once the rate is approved, Employee Agreements and Vendor Agreements must be submitted to the FMA in order to indicate their rate of pay. If an employee or vendor does not submit an Agreement, the FMA will not know the correct rate of pay for the service the employee or vendor is providing. In order for the FMA to pay an employee or vendor, an Employee Agreement or Vendor Agreement needs to be submitted to the FMA. If the pay rate for an employee or vendor needs to be changed, the new rate must be approved by the MCO/UR in FOCoSonline and in the SDCB member’s SDCB care plan and a new Employee Agreement or Vendor Agreement signed by the EOR must be submitted to the FMA at least 15 calendar days before the effective date of the rate change. Please remember that if a change to an employee’s rate of pay is made after the SDCB care plan has started, the change will not be effective until the beginning of the next pay period.

v. Timely-Filing Requirements

In New Mexico, there is a 90-calendar day time limit for filing all Medicaid claims and since SDCB is a Medicaid benefit, the same requirements apply. If timesheets or invoices are submitted more than 90 calendar days after the service has been provided, payment will not be processed and the timesheet or invoice and PRF will be returned to the EOR/Member through the RTM process.
c. SDCB Care Plan Expenditure Safeguards

The SDCB member holds the primary responsibility for monitoring and ensuring that his/her approved SDCB care plan is spent appropriately; however, the care coordinator/support broker must support the SDCB member in this activity. The FMA also assists in ensuring that funds are spent appropriately through payment of approved services and goods according to the approved SDCB care plan and Employee/Vendor Agreements.

The SDCB member is responsible for reviewing his/her monthly spending report which is mailed by the FMA on a monthly basis. The SDCB member may also obtain “real-time” information on service usage and spending through direct access to FOCoSonline. It is highly recommended that members obtain access to FOCoSonline so that they can effectively monitor their budget and track spending. In addition, the EOR and employees may obtain access to FOCoSonline. With FOCoSonline access, the EOR will have the capability to approve timesheets that an employee has entered online. Monthly training for FOCoSonline is offered for SDCB members, employees, and EORs. If interested in training, the SDCB member, employee, or EOR may contact the FMA Help Desk at 1-866-916-0310 for assistance.

The support broker is required to review the member’s SDCB care plan expenditures during each quarterly contact with the SDCB member. The care coordinator/support broker will provide the SDCB member with expenditure information and discuss any concerns. If the SDCB member needs to revise his/her SDCB care plan, the support broker shall assist with drafting the revision and will submit it to the MCO/UR for consideration per established procedures. The care coordinator will also initiate a new CNA as needed.

The FMA is responsible for processing payments for approved SDCB services and goods. When an invoice or timesheet is received by the FMA, they verify that the particular service or good is approved in the SDCB member’s SDCB care plan/budget and payment is processed according to the approved SDCB care plan/budget and Employee/Vendor Agreement. In regards to internet and phone services (landline or cell), the FMA will pay up to the approved monthly amount. This helps to ensure that this category of service is not overspent which could put the SDCB member at-risk of losing these services due to possible non-payment later in the SDCB care plan/budget year. If the FMA is unable to make payment as requested due to lack of funds remaining in the SDCB care plan, the FMA will send a return to member (RTM) letter to the SDCB member and make several attempts to contact the SDCB member by telephone.

d. Community Benefit Transitions

Upon eligibility for the Community Benefit, the member will be eligible for the Agency Based Community Benefit (ABCB). An ABCB member may choose to move to SDCB
anytime but may not move to SDCB until after 120 calendar days in the ABCB. The member must always end the current community benefit on the last day of the month and start the new community benefit on the first day of the following month. There must be no break in services.

17. TERMINATION FROM THE SDCB PROGRAM

a. Voluntary Termination
SDCB members may transfer to the ABCB from the SDCB at any time. To the extent possible, the member shall provide his/her provider(s) 10 business days advance notice regarding his/her intent to withdraw from the participant direction. All transfers must begin on the 1st of the month.

b. Involuntary Termination
SDCB members may be terminated involuntarily and offered services through the ABCB under the following circumstances:

i. The member refuses to follow SDCB rules after receiving: focused technical assistance on multiple occasions; support from the program staff; care coordinator/support broker or, FMA and which is supported by documentation of the efforts to assist the SDCB member;

ii. The member is in immediate risk to his/her health or safety by continued self-direction of services, e.g., the SDCB member is in imminent risk of death or serious bodily injury related to participation in the SDCB. Examples include but are not limited to the following:
   a. The SDCB member refuses to include and maintain services in his/her SDCB care plan that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, care coordinator/support broker, or FMA;
   b. The SDCB member is experiencing significant health or safety needs, and, after having been referred to the State contractor team (that includes the appropriate State program manager and additional parties as deemed necessary by the State) for level of risk determination and assistance, refuses to incorporate the team’s recommendations into his/her SDCB Care Plan;
   c. The SDCB member exhibits behaviors which endanger him/her or others.

iii. The SDCB member misuses SDCB funds following repeated and focused technical assistance and support from the care coordinator/support broker or FMA, which is supported by documentation; and

iv. The SDCB member commits Medicaid fraud.
See also the Appendices that relate to SDCB

Appendix C: Range of Rates and Service Codes
Appendix D: Vendor Credentialing Requirements Grid
Appendix E: Employee Credentialing Requirements Grid
Appendix F: Vendor Payment Request Forms (PRF)
Appendix G: Toolkit: Vendor
Appendix H: Toolkit: Employee
Appendix I: Employer of Record (EOR) Self-Assessment
Appendix J: List of SDCB Acronyms and Services
NEW MEXICO MEDICAID PROGRAM COPAYMENTS

(Final Version as of 12-10-2013)

CHIP RECIPIENT COPAYMENTS  Children’s Health Insurance Plan  Categories of Eligibility 071, 0420, and 0421

Copayment only applies when the federal match code is 1

PHARMACY COPAYMENT:

$ 2 per drug item - Does not apply if the copayment for unnecessary brand name drug utilization is assessed.

See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

PRACTITIONER SERVICES COPAYMENTS:

$ 5 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see “hospital copayments” below. Only one copayment is applied per visit or session.

When the “visit” takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied to the professional charge, not to the facility charge.

HOSPITAL COPAYMENTS:

When the copayment is applied to an inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

$ 15 outpatient emergency room - Does not apply if the

COPAYMENTS FOR UNNECESSARY SERVICES:

$ 5 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL, unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. — See note section on page 7, note 3.

Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)

$ 50 for non emergent use of ER – See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions.
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8 of note 4; and on page 9, item 12 of note 4.
copayment for non-emergent use of the ER is assessed.

$ 25 inpatient admission – Not applied when the hospital receives recipient as a transfer from another hospital.

**EXEMPTIONS**

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. – See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8.
9. Federal match 3 for COE’s 071 and COE’s 420, and 421 because they are presumptively eligible children.

<table>
<thead>
<tr>
<th>PHARMACY COPAYMENT:</th>
<th>COPAYMENTS FOR UNNECESSARY SERVICES:</th>
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<tbody>
<tr>
<td>$ 5 per drug item - Does not apply if the copayment for unnecessary brand name drug utilization is assessed.</td>
<td>$ 8 for a brand name drug when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. See note section on page 7, note 3.</td>
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See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

**PRACTITIONER SERVICES COPAYMENTS:**

$ 7 Outpatient visit to physician or other practitioner, dental visit, therapy session, or behavioral health service session - This copayment is not applied to emergency room professional charges because there is a separate emergency room facility copayment that applies, see “hospital copayments” below. Only one copayment is applied per visit or session.

When the “visit” takes place in an outpatient hospital or urgent care center, which typically involves both a facility component as well as a professional (physician) component charge, the outpatient copayment is applied

$ 28 for non emergent use of ER - See note section on page 6, note 2.

**EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:**

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions
5. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.
to the professional charge, not to the facility charge.

**HOSPITAL COPAYMENT:**

When the copayment is applied to any inpatient service or emergency room service, the copayment is always applied to the hospital charge, not the professional charge.

$20 **outpatient emergency room** - Does not apply if the copayment for unnecessary use of the ER is assessed.

$30 **inpatient admission** - Not applied when the hospital receives recipient as a transfer from another hospital.

**EXEMPTIONS**

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Family planning services, procedures, drugs, supplies, and devices
4. Medicare Cross Over claims including claims from Medicare Advantage Plans
5. Preventive services regardless of age (well child checks, vaccines, preventive dental cleanings/exams, etc. – See note section on page 8, item 7.
6. Prenatal & postpartum care and deliveries, and prenatal drug items
7. Provider preventable conditions
8. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.

**ABP - ALTERNATIVE BENEFIT PLAN COPAYMENTS** Category of Eligibility 100 - APPLIES ONLY TO ABP RECIPIENTS WHO ARE 101% - 138% FPL

► (For ABP recipients who are at an FPL of 100% or below, or who are ABP Exempt, the only copayments that can apply are for unnecessary use of a brand name drug and unnecessary use of an ER, see page 6)

**PHARMACY COPAYMENT:**

$3 **per drug item** Does not apply if the copayment for unnecessary brand name drug utilization is assessed.

See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items

**COPAYMENTS FOR UNNECESSARY SERVICES:**

$8 **For a brand name drug** when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse
and some behavioral health drugs.

**PRACTITIONER SERVICES COPAYMENTS:**

**$8 Outpatient visit** to physician or other practitioner, dental visit, rehabilitative or habilitative therapy session.

This copayment applies in places of service such as offices, outpatient hospitals (other than emergency rooms), clinics, and urgent care centers. It is applied to the professional service, not to any facility charge.

These practitioner services copayments do not apply to emergency room facility or emergency room professional charges because of the exemption for emergency services.

**HOSPITAL COPAYMENTS**

**$25 inpatient admission** - A copayment is not applied when the hospital is receiving the recipient as a transfer from another hospital or when the recipient is admitted through the emergency room.

When the copayment is applied to an inpatient service, the copayment is always applied to the hospital charge, not the professional charge.

**EXEMPTIONS for ABP**

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Emergency services, See note section on page 6, note 1.
4. Family planning services, drugs, procedures, supplies, and devices
5. Hospice patients
6. Medicare Cross Over claims including claims from Medicare Advantage Plans
7. Pregnant women - all services unless MAD gets approval from CMS to exempt some services as not pregnancy related; so currently all services for pregnant women are exempt.
8. Prenatal & postpartum care and deliveries, and prenatal drug items
9. Mental health (behavioral health) and substance abuse services, including
   - Psychotropic drug items are exempt from the brand name copayment (only the regular pharmacy copayment applies)
   - See note section on page 7, note 3.
   - $8 For non emergent use of ER
   - See note section on page 6, note 2.

**EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:**

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions

When the maximum family out of pocket expense has been reached. See note section on page 8, item 8.
10. All preventive services
11. Provider preventable conditions
12. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8; and on page 9, item 12 of note 4.
13. Emergency services

Note: The usual ABP copayments do not apply to an ABP-exempt recipient. The only copayments that apply to the ABP exempt recipient or to an ABP recipient at 100% FPL or below are those for unnecessary use of a brand name or an ER. See page 6, other recipients.

The ABP exempt recipient is identified by having a “disability type code” on the eligibility file of ME or PH.

**Emergency Services Exemption for Above ABP Copayments**

- The ABP copayments do not apply when treatment is for an “exempt emergency service” as described in the Social Security Act and CFR.
- These provisions clearly exempt all medically necessary emergency room services from copays. However, there may be additional situations that qualify as emergency services.
- For additional information on this provision, see note section on page 6, note 1.

**OTHER MEDICAID RECIPIENTS**  Note that if the FPL is not available on January 1, 2014, use the lower copayment until the FPL is available.

Applies to:

1. **ABP recipients who have an FPL at 100% or below**
2. **ABP Exempt recipients**
3. **Other standard Medicaid recipients except for recipients in foster care, adoption programs, or institutional categories of eligibility**

These recipients who have “standard” Medicaid eligibility, so they generally do not have copayments on services. However, the can be assessed a copayment for non-emergent use of the ER or for unnecessary use of a brand name, unless they are one of the following categories of eligibility.

**COPAYMENTS FOR UNNECESSARY SERVICES:**

$3 **For a brand name drug** when there is a less expensive therapeutically equivalent drug on the PDL unless the prescriber determines the alternative drug on the PDL will be less effective or have greater adverse reactions. – See
CATEGORIES OF ELIGIBILITY FOR WHOM THE COPAYMENTS FOR NON EMERGENT USE OF THE ER AND UNNECESSARY USE OF BRAND NAMES DO NOT APPLY:

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<td>087</td>
<td>foster care</td>
</tr>
<tr>
<td>047</td>
<td>adoption</td>
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</tbody>
</table>

OTHER EXEMPTIONS:

1. Native Americans (race code 3)
2. Services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. For psychotropic drug items (minor tranquilizers, sedatives, hypnotics and stimulants to treat attention deficit disorders are not considered psychotropic medications for the purpose of this provision.)
5. Provider preventable conditions
6. When the maximum family out of pocket expense has been reached. See note section on page 8, item 8, and on page 9, item 12 of note 4.

Note:

- There is no copayment for drug items other than the unnecessary use of a brand name.
- There are no payments for practitioner services, hospital services, or emergency room services other than the non emergent use of the ER.

FOR NON EMERGENT USE OF THE EMERGENCY ROOM -

**Varies by FPL:**

- $ 8 for 150% FPL or below
- $50 for greater than 150% FPL

See note section on page 6, note 2.

EXEMPTIONS from copayments for unnecessary brand name drug use or ER use:

1. Native Americans (race code 3)
2. All services rendered by an IHS, 638 facility, or Urban Indian Facility regardless of race code
3. Medicare Cross Over claims including claims from Medicare Advantage Plans
4. Provider preventable conditions

When the maximum family out of pocket expense has been reached. See note section on page 8, item 8.

Note 1: Alternative Benchmark Plans: Notes on the Exemption from Copayments for Emergency Services

Exempt emergency services (federal definitions): “Emergency medical condition means 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 the following:

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) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

*Emergency services* means covered inpatient and outpatient services that are as follows:

(1) Furnished by a provider that is qualified to furnish these services under this title.

(2) Needed to evaluate or stabilize an emergency medical condition.

**Provider Responsibilities:**

- The MCO is responsible for setting up their process which may include requirements for the provider to identify when a copayment is exempt because the service is an emergency.

**MCO Responsibilities:**

- To not apply the ABP copayment to services in emergency rooms. Unless, the non-emergent use of the emergency room copayment is assessed, an emergency room service is presumed to be an emergency. Very likely, an inpatient hospital stay when the admission is through an emergency department, the inpatient hospital stay qualifies as an emergency.

- To develop their own rules and process consistent with the federal requirements. MAD can provide direction as necessary.

- To recognize when other providers report the service as exempt from the copayment because it is an emergency. In which case the MCO does not deduct the ABP copayment from the amount paid to the provider.

**Note 2: Assessing a Copayment for Non-Emergent Use of the Emergency Room**

**Hospital Responsibilities:**

- The hospital provider will determine if the recipient is using the emergency room for a non-emergent service. In making this determination, the hospital must consider the medical presentation of the recipient, age, and other factors, as well as alternatives that may be available in the community, the time of day, etc.

- The hospital must provide an appropriate level of screening to determine whether the service constitutes an emergency. Before assessing the copayment, the hospital must provide the individual with the name and contact information for an alternative provider that can provide the services in a timely manner with a lesser or no copayment (depending on the recipient’s category.) If the recipient chooses to go to the alternative provider, the hospital assists with making an appointment for the recipient. Depending on the day and the time, this may include helping contact the alternative provider or providing the name(s) and phone number(s) of the providers, directions, etc. If geographical or other circumstances prevent the hospital from meeting this requirement, the cost sharing may not be imposed.

- The hospital must tell the recipient the amount of the copayment. If the recipient agrees to go with an alternative, the copayment for non-emergent use of the ER is not assessed by the hospital.

- If the recipient wants to continue to receive emergency room services beyond that initial screening, the hospital assesses the co-payment.

- When the hospital assesses the copayment, it is reported to the MCO, and the MCO reduces the payment to the hospital by the copayment amount. If the hospital is not able to collect the copayment amount, the copayment amount should not be deducted from the hospital payment.

**MCO Responsibilities:**

- To recognize when the copayment has been assessed by the hospital and collected from the recipient, and
only then to reduce the payment to the hospital by the copayment amount.

**Note 3: Assessing a Copayment for Unnecessary Use of a Brand Name Drug**

The copayment for unnecessary use of a brand name drug is applied to a brand name drug that is NOT on the PDL, with the following limitations:

- If in the prescriber’s estimation, the alternative drug item available on the PDL is either less effective for treating the recipient’s condition, or would have more side effects or higher potential for adverse reactions, the copayment cannot be applied. Presumably, if the MCO approved the use of a brand name drug NOT on the PDL for one of these reasons, then the copayment cannot be applied.
- If the prescriber has stated the brand is medically necessary and therefore the claim is billed with a dispense as written indicator, the copayment cannot be applied unless the MCO ascertains the reason for the brand being medically necessary is something other than the fact that the generic form is anticipated to have more side effects or adverse reactions, or would be less effective in treating the recipient.

**MCO Responsibilities:**

- The MCO should consider how to construct a PDL in order to apply this copayment. For example, maybe only a first tier drug item is called the “PDL” while a second tier is maybe called something else, maybe “Alternatives”.
- The MCO must determine the means by which a copayment on a brand name drug will not be applied when the above conditions are met.

**Note 4: General Rules for all copayments**

1. Native Americans are always exempt from all these copayments.
2. A provider is NOT able to refuse services to the recipient when the recipient is unable to pay the copayment at the time of service. However, the provider is still required to apply the copayment by billing the recipient or trying to collect it at a future visit.
3. Only one copayment can be charged per visit or encounter. There are no other copayments applied during an inpatient stay other than the one applied for hospital admission.
4. Except for non-emergent use of the ER, the MCO must assume the copayment applies and must deduct the applicable copayment from the claim prior to paying the provider regardless of whether the copayment was actually collected by the provider unless:
   - The recipient or service is exempt from copayment per the criteria on this chart, or
   - The service is exempt based on information from the provider (such as a service to an ABP recipient being an emergency) or
   - The recipient is exempt from the copayment because the total copayments paid by the family exceed 5% of the family’s income in which case this information is communicated to the MCO.
5. For non-emergent use of the ER, the MCO should assume the copayment for the unnecessary use does not apply, unless indicated by the hospital provider that the copayment has been assessed.
6. There may be instances where the MCO may not know when the use of a brand name drug item should not be subjected to the unnecessary use of a brand name copayment. The MCO must formulate their procedures for this process.
7. Ideally, the concept of what constitutes preventive care will be standard across all MCO’s, but the effort to accomplish this will have to come in the future, probably after the implementation Centennial Care. MAD will give direction as necessary. Note that this concept of “preventive care” is not necessarily the same as the list produced by CMS for the ABP plan, which is often limited by age or frequency and does not generally consider risk factors and other conditions that may make a service preventive in nature.
8. Exceeding the 5% of the family income:
In order to determine if an individual is exempt from copayment, the MCO will have to accumulate the amount of copayments for every member in the family using the case number. When those accumulated copayments reach the family out of pocket maximum expense, then all members of the family are exempt from copayments.

- Example: If John Jr. had a $50 copayment, and Suzie Jr. had a $50 copayment, and the family out of pocket maximum for the quarter is $100, when little Robbie has a service and the copayment is $5, the family out of pocket maximum for the quarter has already been met. Little Robbie doesn’t have to make a copayment. In other words, it is the total amount that has been deducted from provider payments as copayments for all members of the family, not the individual, that are accumulated and compared to the family out of pocket maximum for the quarter.

Copayments for unnecessary use of brand name drugs or ER non emergency use are also included in the accumulation of the total family out of pocket maximum for the quarter.

9. When other insurance has paid for the service and the amount being paid by an MCO is toward the co-insurance and deductible, copayments are not applied.

10. Copayments are never applied to services that are considered Community Benefits under the MCO contract and rules.

11. Copayments are not applied to services that were rendered prior to eligibility being established, even though retroactive eligibility later covers the time period during which the service was rendered.

12. The MCO must track, by quarter, all co-payments applied to claims for each individual member in the household family to ensure that the family does not exceed the aggregate out-of-pocket maximum (OOP). The OOP is five percent of countable family income for all individual members in a household family calculated as applicable for a quarter. The MCO must be able to provide each member, at his or her request, with information regarding co-payments that have been applied to claims for the member.

13. The MCO must report to the provider when a copayment has been applied to the provider’s claim and when a copayment was not applied to the provider’s claim. This is done, at a minimum, using the remittance advice, EOB, or equivalent electronic transaction. The MCO shall be responsible for assuring the provider is aware that:

- The provider shall be responsible for refunding to the member any copayments the provider collects after the eligible recipient has reached the co-payment out-of-pocket maximum (five percent of the eligible recipient’s family’s income, calculated on a quarterly basis) which occurs because the MCO was not able to inform the provider of the exemption from copayment due to the timing of claims processing.

- The provider shall be responsible for refunding to the member any copayments the provider collects for which the MCO did not deduct the payment from the provider’s payment whether the discrepancy occurs because of provider error or MCO error.
9 MARKETING

Revision Dates: January 1, 2014
Review Date: January 1, 2014
Initial Effective Date: January 1, 2014

A. Purpose

This policy establishes guidelines and restrictions for all MCOs awarded a contract and subcontractors of the MCO, or under contract with HSD to deliver health care services, for marketing and outreach activities referencing the managed care program.

B. Definitions

Health Education: Programs, services or promotions that are designed or intended to advise or inform the MCOs enrolled members about issues related to healthy lifestyles, situations that affect or influence health status, behaviors that affect or influence health status or methods of medical treatment.

Health Educational Materials: Materials that are designed, intended, or used for health education or outreach to the MCOs actual members. Health education materials include, but are not limited to: condition specific brochures, letters or phone calls, member newsletters, posters and member handbooks.

Incentives: Items that are used to encourage behavior changes in the MCOs enrolled members or health promotion incentives used to motivate members to adopt a healthy life style and/or obtain specific health care services. These may include but are not limited to:

- infant car seats or baby item giveaways
- gift cards
- manufacturer or coupons for savings on products; or
- service’s or any other objects that are designed or intended to be used in health education or outreach.

Incentives may not be used in conjunction with the distribution of alcohol or tobacco products.

Marketing: Any medium of communication that is written, audio/oral, personal face-to-face, or electronic, including any promotional activities, intended to increase the MCOs or subcontractors membership or to “Brand” a MCO or subcontractors name or organization.
**Marketing Materials:** General audience materials such as: general circulation of brochures, flyers, newspaper, phone book advertisements, websites and/or any other materials that are designed, intended, or used for increasing the MCOs or subcontractors membership or establishing a brand. Such marketing materials may include but are not limited to: scripts, provider directories, leaflets, posters or any material that is distributed or circulated by the MCO and subcontractors, including providers (e.g. personal care providers).

**Outreach:** Any means of educating or informing the MCOs enrolled members about health issues. See also “health education” and “retention”.

**Outreach Materials:** Materials that are designed, intended, or used for health educational or outreach purposes only to the MCOs enrolled members. See “Health Education Materials”.

**Event Promotion:** Any activity in which any approved marketing materials are given away or displayed where the intent is to provide health education and/or outreach.

**Event Promotional Materials:** See “marketing materials”.

**Provider:** A hospital/hospital staff, physician/physician staff, pharmacy/pharmacist, ancillary service providers and their staff, personal care/homemaker providers and their staff.

**C. Policy**

Marketing is the information intended for the general public about the existence of the MCO and its subcontractors and the availability of the MCO as an enrollment option for people upon being deemed eligible to for services through Managed Care.

Outreach is communication with enrolled members for the purpose of member retention, and improving the health status of enrolled members. Retention efforts must be directed to currently enrolled members who are determined to be at risk for attrition, or analysis of membership trends such as decreased utilization of preventative services.

For marketing, outreach, retention activities and materials, the MCO must first submit for review and approval by HSD. In addition to the approval, the MCO must provide HSD with a copy of the approved material, advertising copy or publication in which the ad will be placed.

**D. Procedure**

1. **MCO Submissions**
   a) **Materials**
      The use of any material, including those that pertain to incentives, marketing, outreach, and promotions must have prior approval from the HSD Marketing Committee. Materials that have been previously approved but will be included in a
specific activity must also be included in the MCOs submission for review and approval by HSD.

MCOs shall review all their material on a regular basis and revise materials as necessary. Any revised or updated material previously approved must be submitted to HSD in advance for approval.

b) Events
   MCOs may participate in health-related marketing and outreach events that are “Pre-Approved” by HSD. Events must be health related or have health education components. MCO participation in these events must be substantive; an unmanned booth(s) with handouts is not acceptable.

   The MCO shall submit to the HSD Marketing Committee all marketing outreach events that the MCO was a participant. Participation includes but is not limited to having a booth at the event, financially contributing to the event and/or having a presence at the event.

   The MCO shall submit an annual Marketing & Outreach Plan as well as a quarterly report which outlines the MCOs activities. The report shall include the following:

   The HSD Marketing Committee and HSD MCO Contract Manager will review the MCOs annual Marketing & Outreach plan and quarterly report to determine if the MCOs participation in any events were in violation of this policy. If HSD determines the MCO was in violation of this policy, the MCO may be subject to sanctions. Failure by the MCO to disclose any event attended may also result in Administrative Action.

c) MCO Health Plan Name and Logos
   MCO Health Plan Name and Logos can be included on event flyers or websites that are produced by hosting organizations without prior approval. MCO must monitor and police their health plan name and logo use to prevent misuse.

2. HSD Marketing Committee Approval
   The HSD Marketing Committee will attempt to approve or deny the requests within 15 business days of the receipt of the complete request. The “15 day” timeframe for approval shall only apply to the specific date of the initial submission. Modifications of any type would need to be resubmitted, which may delay approval.

3. Restrictions
   The following restrictions apply to all marketing, outreach and retention activities. The following shall not be allowed:
a) Incentive items such as t-shirts, buttons, balloons, key chains, etc. unless the intent of such a give-away is outreach in nature (i.e. for educating members about benefits of safety, immunizations, well-care, or as a “reward/incentive” for member accessing care as part of an approved incentive program). All incentive items must be prior approved by the HSD Marketing Committee.

b) Solicitation of any individual face-to-face, door-to-door or cold call telemarketing, including that of the MCOs subcontractors;

c) Any reference to competing plans

d) Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;

e) Unsolicited direct mail advertising, including that of the MCOs subcontractors;

f) Marketing of non-covered services.

g) Reference to the word “free” for any covered service;

h) Use of HSD/MAD logo

i) Inaccurate, misleading, confusing or negative information about HSD, or statements designed to recruit potential members, including that of the MCOs subcontractors;

j) Discriminatory marketing practices

k) The MCO may not encourage or persuade the member to select a particular MCO plan or subcontracted provider when completing specific applications or forms. The MCO or subcontractor may not complete any portion of the application or forms on behalf of the potential enrollee. The prohibition covers all situations, whether sponsored by the MCO, their parent company, or any other entity.

HSD reserves the right to impose additional restrictions at any time.

4. When materials are submitted for review, the MCO shall ensure that:

a) All materials identify the MCO as an HSD/MAD managed care provider and are consistent with all the requirements for information to members described in the contract, regulations and managed care policies and procedures.

b) All materials shall specify “Such services are funded in part with the State of New Mexico”.

c) All materials shall include information that describes what the submission is, its purpose and what population (if applicable) it will target. This information may be submitted in form of a cover letter, MCO Contractor plan form, or in the body of an email.

d) All materials two or more pages must be numbered.

e) All materials must be 6th grade reading level or lower and each submission must provide the reading level with and without, proper names, medical terminology, etc.

f) All materials must indicate if a translated version will be made available to the member and or how the member can request a translated version.
g) All materials must be submitted timely and at least 30 calendar days prior to use allowing the HSD Marketing Committee at least 15 business days to review. If an “Expedited” review is needed, please submit and allow at least five (5) business days for review and approval or request special accommodations for unique circumstances.

h) All materials used for any type of Medicaid or managed care training purposes must be submitted for review and approval before training occurs (i.e. handouts, power points, etc.). If MCO plans are collaborating and conducting one training using the same power point presentation, one MCO plan should be designated and submit the material on behalf of all MCOs (e.g. Annual Tribal Meetings).

i) All materials that correspond with each other should be submitted to HSD for review together, in lieu of separate submissions.

j) All approved materials shall be provided in a printed, hard copy to the HSD Marketing Liaison in the English and translated Spanish version (if applicable).

k) Outreach material may not include the words: “free”, “join”, “enroll”, “sign up” or similar verbiage unless approved by the HSD Marketing Committee. If the MCO intends on using such language in any of the materials, the request for approval must include how the message is related to an Outreach goal.

l) The MCO shall ensure that subcontractors are advised that they too must comply with this policy. All materials must be submitted by all subcontractors to the MCO for review and approval based on the MCO specific policies and procedures for marketing.

5. Sanctions/Penalties

Any violation of this policy may result in the sanctions as described in 7.3 of the contract.

The MCO Contractor shall ensure that all subcontractors are advised that they must comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.

All subcontractors must only advertise the services in which they provide and must not make any reference to HSD/MAD Programs, Medicaid or services in which the MCO Contractor provides.

a) Temporary Sanctions/Penalties

Any activities or materials found in violation of this policy will be subject to sanction regardless of previous approval or terms in contractual agreements. The MCO Contractor will be placed on “Moratorium” status and will not be allowed to advertise the following:

i. Radio advertising;

ii. Billboards;

iii. Bus Wraps (including bus stops)
The MCO Contractor will monitor its subcontractors found in violation of this policy and impose any temporary sanctions for marketing or advertising of the subcontractors services and/or business.

The HSD Marketing Review Committee will review the “Moratorium” status on an annual basis and determine if the MCO Contractor or subcontractor is now deemed compliant.

6. References

- HSD/MAD Managed Care Contract
10 Patient Centered Initiatives

Revision Dates: January 1, 2014
Review Date: January 1, 2014
Initial
Effective Date: January 1, 2014

A. Broad Standards:

1. The Managed Care Organization (MCO) shall establish a patient centered initiative based on the National Committee for Quality (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JHACO) or Accreditation Association for Ambulatory Health Care (AAAHC) Patient-Centered Medical Home (PCMH) recognition program.

2. The MCO shall develop a patient-centered, “whole person” model of care that emphasizes primary medical care that is comprehensive, team-based, coordinated, accessible and focused on quality and safety.

B. Eligible Providers:

1. The MCO shall develop PCMH initiatives with Primary Care physicians (DO or MD), Nurse Practitioners or Physician Assistants as defined by MAD regulation.

C. Patient Centered Medical Home (PCMH):

1. PCMH Principles
   a) Every Member has a Primary Care Provider (PCP)
   b) Care is provided by a physician-directed team that collectively cares for the Member; and
   c) Care is coordinated and/or integrated across all aspects of health.

2. PCMH Model
   The MCO shall develop PCMH models that:
   a) Provide patient-centered care;
   b) Practice evidence-based medicine;
   c) Participate in continuous quality improvement;
   d) Engage patients to actively participate in decision-making and provide feedback related to their care;
   e) Use Health Information Technology (HIT) and promote data exchange through a Health Information Exchange (HIE) to support care delivery; and
f) Provide enhanced access to care including but not limited to extended office hours outside of 8:00 AM to 5:00 PM (Mountain Time), open scheduling, and alternative modes of communication including web-based or telephonic options.

3. PCMH Standards
a) Access to care (i.e. same day appointments, extended hours, group and e-visits, and patient portals). Appointments based on condition and the provider can accommodate same day scheduling as needed.
   i. In-person access
   ii. After-hours access
   iii. Telephone and electronic access
b) Accountability
   i. Performance and clinical quality improvement
c) Comprehensive whole person care
   i. Preventive services
   ii. Medical services
   iii. Mental health, substance abuse, and developmental services
   iv. Comprehensive health assessment and intervention scope of Services
d) Continuity
   i. Personal clinician assigned
   ii. Personal clinician continuity
   iii. Organization of clinical information
   iv. Clinical information exchange
   v. Specialized care setting
e) Coordination and Integration
   i. Population data management
   ii. Electronic health record
   iii. Care coordination
   iv. Test & result tracking
   v. Referral & specialty care coordination
   vi. Comprehensive care planning
   vii. End of life planning
f) Person and family centered care
   i. Language / cultural interpretation
   ii. Education & self-management support
   iii. Experience of care

4. PCMH Participation Requirements:
   In order to participate, practitioners must:
   a) Meet the six PCMH standards outlined above
   b) Adopt and implement evidence-based diagnosis and treatment guidelines
c) Fully implement an electronic medical record system and participate in the NM Health Information Exchange (HIE)
d) Identify and partner with the MCO to manage high need patients; implement a system for care coordination
e) Measure and report PCMH quality measures as defined by the HSD/MAD which may include HEDIS or patient satisfaction data
f) Have a continuous quality improvement plan that references medical home standards

D. **School Based Health Center Medical Homes**

The MCO shall develop a medical home model of care for School Based Health Centers (SBHC) that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate for youth. The SBHC medical home model core elements include:

1. **Enhance access and continuity that includes:**
   a) Access during office hours; includes same day scheduling and telephone access
   b) After-hours access; after hours clinical advice via phone/electronic access to providers
   c) Continuity/Coordination; each student assigned a personal physician and practice is responsible for coordinating care
   d) Students receive information about the role of the medical home; coordinating care, getting advice after hours, responsibility to share information about care received in other places and self management
   e) Meet cultural, linguistic and health needs of the population served

2. **Identify and manage patient population that includes:**
   a) Collect and use data for population management; identify students in need of preventive or chronic care services, those have not recently been seen by a practitioner or those with specific medications
   b) Patient Information and clinical data collected and entered into an Electronic Health Record (EHR); demographics, health insurance, and vital stats (height, weight, BMI, plotted on a growth chart)
   c) Comprehensive health assessment completed for each student; immunization assessment, family/social/cultural issues, depression screening, tobacco use, behaviors affecting health and medical history

3. **Plan and manage care that includes:**
   a) Care management; providing a written plan of care to student/family
   b) Identify high risk students
   c) Implement evidence based guidelines
   d) Medication management and E-prescribing
4. Provide self-care support and community resources that includes:
   a) Support self-care process; develop self management plan and provide educational resources
   b) Provide referrals to community resources; maintain a list of key community resources

5. Track and coordinate care that includes:
   a) Referral tracking and follow-up
   b) Test tracking and follow up; flag abnormal tests
   c) Manage transitions; including to adult care

6. Measure and improve care that includes:
   a) Measure performance to improve clinical quality; for at least three (3) preventive or chronic conditions
   b) Measure student experience at the SBHC
   c) Implement Continuous Quality Improvement

E. PCMH Monitoring

1. The MCO shall use a standardized set of measurements including: utilization, cost and quality measures to monitor:
   a) Preventive care
   b) Chronic disease management
   c) Acute care
   d) Over utilization
   e) Safety

2. The MCO shall measure patient satisfaction using surveys and other predefined sources of information annually.

F. PCMH Payment Methodology

1. An enhanced payment methodology for PCMHs must be standardized between all contracted MCOs
2. Methodology may include:
   a) Ongoing fee-for-service payments
   b) Tiered per member per month (PMPM) payment based on PCMH recognition level including a base level if practice is not NCQA, JHACO, or AAAHC recognized.
   c) Enhanced payment to practices that meet quality targets (pay for performance)
   d) Shared savings model
G. Health Homes

1. The MCO shall comply with Section 2703 of the Patient Protection and Affordable Care Act (PPACA) and in accordance with the Medicaid State Plan Amendment to provide a comprehensive system of care coordination for individuals with chronic conditions.

2. Health home providers must integrate and coordinate all primary, acute, behavioral health and long-term care services that support and treat the whole-person across the lifespan.

3. Health Home Core Services
   a) Comprehensive Care Management; must include:
      i. Assessment of preliminary risk conditions and health needs;
      ii. Care Management Plan development, which will include client goals, preferences and optimal clinical outcome and identify specific additional health screenings required based on the individual’s risk assessment;
      iii. Assignment of health team roles and responsibilities;
      iv. Development of treatment guidelines for health teams to follow across risk levels or health conditions;
      v. Oversight of the implementation of the Care Management Plan which bridges treatment and wellness support across behavioral health and primary care;
      vi. Through claims-based data sets and patient registries, monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and
      vii. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
   b) Care Coordination; the implementation of the individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports.
      i. Developed in active partnership with the member and the member’s family, as appropriate
      ii. Promotes integration and cooperation among service providers and reinforces treatment strategies that support the member’s motivation to better understand and actively self-manage his or her health condition
      iii. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and client/family members
   c) Comprehensive Transitional Care; coordinating plans of care, reducing hospital admissions, easing the transition to long term services and supports and interrupting patterns of frequent hospital emergency department use.
      i. Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment
plan with a specific focus on enhancing clients’ and family members’ ability to manage care and live safely in the community, and enhancing the use of proactive health promotion and self management.

d) Health Promotion; services must include:
   i. Provide health education specific to an individual’s chronic conditions;
   ii. Development of self-management plans with the individual;
   iii. Education regarding the importance of immunizations and screening for overall general health;
   iv. Providing support for improving social networks;
   v. Providing health-promoting lifestyle interventions, including but not limited to: substance use prevention and/or reduction; smoking prevention and cessation; nutritional counseling, obesity reduction and prevention and increasing physical activity; and
   vi. Reinforce strategies that support the member’s motivation to better understand and actively self-manage her or his chronic health condition.

e) Individual and Family Support; services must include, but are not limited to:
   i. Navigating the health care system to access needed services;
   ii. Assisting with obtaining and adhering to medications and other prescribed treatments;
   iii. Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
   iv. Arranging for transportation to medically necessary services.

f) Referral to Community and Social Support Services; services include:
   i. Identifying available community-based resources
   ii. Actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement
   iii. Common linkages could include continuation of healthcare benefits, eligibility, disability benefits, housing, legal services, educational supports, employment supports, and other personal needs consistent with recovery goals and the treatment plan.

H. Health Home Payment Methodology

1. An enhanced payment methodology for Health Homes must be standardized between all contracted MCOs
2. Per member per month (PMPM) payment will be based on HSD/MAD staffing model requirements
3. PMPM payment will be made to practices that meet HSD/MAD directed principles, standards and participation requirements.
11 ALTERNATIVE BENEFIT PACKAGE

Revision Dates: January 1, 2014

Review Date: January 1, 2014

Initial

Effective Date: January 1, 2014

Upon the Other Adult Group’s (COE 100) member’s self-identification, or through the care coordination process, the MCO shall evaluate and confirm whether the member qualifies as Medically Frail based on the criteria attached to this policy manual. The MCO shall confirm the member’s status and notify the member by mail within 10 business days of the member’s self-identification to the TPA. When the member has chosen the ABP Exempt benefit package, the MCO should make the indication in Omnicaid using a Disability Type Code of ME (for a serious mental illness, substance use disorder or other mental disability) or PH (for a physical health disability).

See the following appendices:

Appendix K: ABP Benefit Chart

Appendix L: Alternative Benefit Plan-Exempt Medically Frail Conditions List

Appendix M: Chronic Substance Dependency Checklist

Appendix N: SMI Checklist

Appendix O: NF LOC Supplement
12 SCHOOL-BASED HEALTH CENTERS

Revision Dates: January 1, 2014
Review Date: January 1, 2014
Initial Effective Date: January 1, 2014

A. SBHC Program Overview

School-Based Health Centers (SBHCs) are a vital part of the healthcare delivery system in New Mexico. They are comprehensive primary health care centers on school grounds that provide physical and behavioral health services to students. Working with the NM Department of Health, Office of School and Adolescent Health (DOH/OSAH) and the Managed Care Organizations (MCOs) who help insure Medicaid-eligible students and families, the HSD/MAD/SHO strives to offer “the right care, at the right time, in the right setting” – in this case at schools where students spend much of their time.

In 2012-2013, the 56 school campuses with SBHCs supported by Human Services Department, Medical Assistance Division School Health Office (HSD/MAD/SHO) and DOH/OSAH served 14,500 students and were accessible to 33,000 students in various regions and demographics throughout New Mexico. Of those served, 40% do not have (or do not know of) another place to receive healthcare.

SBHCs have been found to be especially effective in offering developmentally and culturally appropriate primary care, preventative services, and behavioral health services for students in rural areas where other health care options are limited. Areas of particular focus and strength of services offered by SBHCs include:

- Health screenings - Early and Periodic Screening, Diagnosis, Treatment (EPSDT)
- Asthma screening and management
- Obesity and Diabetes type-2 screening and management
- Depression and anxiety screening and treatment
- STI and reproductive health services
- Care coordination

SBHCs promote positive health behaviors and healthcare literacy by increasing healthy knowledge and decision-making skills in the students they serve. And by serving students in a school setting, SBHCs limit the amount of time students miss school to receive healthcare
services, leading to increased in-class time and fewer absences for a positive effect on student academics as well as positive health outcomes.

SBHCs are uniquely positioned to be on the ground members of the care coordination team and should be centrally involved in reaching and working with student members: SBHCs can assist the MCO with reaching the student member to conduct the initial risk level assignment. SBHCs use a comprehensive risk and resiliency-screening instrument called the Student Health Questionnaire (SHQ). The SHQ identifies a student’s current health needs, presence of mental health issues and/or substance abuse, and living arrangements. Through the SHQ, SBHCs often identify higher risk students, i.e., those who are medically complex or fragile, have high emergency room use, have a high risk mental health diagnosis or are seriously and persistently mentally ill, and homeless; SBHCs can be utilized after the initial risk assignment to complete a more comprehensive assessment of the student member who appears to have a higher level need for care coordination; SBHCs, based on the assessment, can then participate with students, families and the MCOs in development and implementation of the students’ care plans.

The HSD/MAD/SHO supports School-Based Health Centers by providing Medicaid claims reimbursements through MCOs, ensuring that SBHCs and their medical providers get paid for their services to Medicaid clients as appropriate. Working with DOH/OSAH, HSD/MAD/SHO helps certify SBHCs to ensure they meet state quality standards. HSD/MAD/SHO also promotes quality improvement of SBHCs so they can offer the best services possible.

B. SBHC Certification Site Review Process

- FQHC/Medical Entity Sponsored Sites

1. MCO Responsibilities
   The MCOs will be responsible for doing the certification visits for SBHC sites that are sponsored by a FQHC or other medical entity (i.e., hospital). The MCOs will visit and certify the sponsoring entity and sponsoring entities will then be responsible for making sure that the sites adhere to the Standards and Benchmarks for Participation as required by DOH/OSAH. The MCOs will communicate the results of these visits with DOH/HSD.

2. DOH/HSD Responsibilities
   DOH/OSAH will communicate with the MCOs which SBHC sites are under the sponsorship of a FQHC or other medical entity. DOH/OSAH will do visits to individual SBHC sites to ensure that the Standards and Benchmarks for Participation are being appropriately adhered to. If DOH/OSAH finds serious deficiencies that they feel may affect Medicaid billing, they will place the site on a Corrective Action
Plan (CAP) and request that HSD/MAD/SHO participate in a return visit to ensure the CAP has been properly implemented. HSD/MAD/SHO will retain the ability to suspend Medicaid billing privileges for any sites that does not adhere to the Standards and Benchmarks for Participation.

- Independent/Non-Medical Entity Sponsored Sites

DOH/OSAH and HSD/MAD/SHO will maintain the current process of a joint certification site review process for “independent” sites that are sponsored by non-medical entities (i.e., non-profits, universities, Regional Education Cooperatives (RECs)) to ensure that the Standards and Benchmarks for Participation are being appropriately adhered to. This site review will also serve as the certification to the MCOs that the site is allowed to participate in Medicaid billing. Sites found to be in non-compliance the Standards and Benchmarks for Participation will be placed on a Corrective Action Plan that will be monitored by DOH/OSAH and HSD/MAD/SHO. All deficiencies will need to be corrected before a site is certified/re-certified for participation in Medicaid billing. The results of the site reviews will be communicated with the MCOs.

C. Confidential Services and Suppression of Explanation of Benefits (EOBs) for SBHC Services

Under New Mexico law, there are a number of circumstances in which an adolescent (an un-emancipated minor) may consent to receive services without parental consent, including the following:

1. Treatment for Sexually Transmitted Diseases:
   Under Section 24-1-9 (capacity to consent to examination and treatment for a sexually transmitted disease), any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease; however, under Section 24-1-9.4, disclosure of the test results is authorized “to the subject of the test or the subject’s legally authorized representative, guardian or legal custodian.”

2. Pregnancy Examination and Diagnosis:
   Under Section 24-1-13 (pregnancy; capacity to consent to examination and diagnosis), any person, regardless of age, has the capacity to consent to an examination by a licensed physician for pregnancy.

3. Family Planning Services:
Under Section 24-8-5 (prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services) there are no prerequisites for parental consent to obtain family planning services.

4. Behavioral Health Services:
Under Section 32A-6-14 (treatment and habilitation of children; liability), parental consent is not required to receive “individual psychotherapy, group psychotherapy, guidance, counseling or other forms of verbal therapy that do not include any aversive stimuli or substantial deprivations.”

D. MCO Responsibilities

1. The New Mexico Human Services Department’s (HSD’s) contracts with the MCOs require that the MCOs adopt and implement written confidentiality policies and procedures that conform to state and federal laws and regulations.

2. The MCOs are contractually required to preserve adolescent members’ confidentiality rights. The MCOs are required to honor adolescent members’ rights to receive confidential services to the same extent that they are required to ensure adult members’ privacy rights under HIPAA and other state and federal confidentiality provisions.

3. The MCOs are contractually required by HSD to identify third-party coverage and coordinate benefits with applicable third parties. However, for purposes of the SBHC/MCO project, this requirement has been waived by HSD since it applies to seeking coverage of confidential services first from private third-party payors. SBHCs should not bill private payors for services rendered to an adolescent who, according to state law, consented to receive them without parental knowledge.

4. The MCOs are to suspend the distribution of Explanation of Benefits (EOBs) for all services provided at SBHCs.
FQHC/Tribal 638 Claims Processing (Alamo and Pine Hill)

- MCOs must configure their systems to pay claims either off of the COBA file or paper claims and pay up to the Medicare OMB rate for the applicable year.

- For I.H.S. and Tribal 638 facilities when there is a Medicare reimbursement for services that are not included in the Office of Management and Budget (OMB) rate, for services billed on a Universal Billing (UB) claim form (used by hospitals and facilities), Medicaid pays the co-insurance and deductible calculated by Medicare regardless of the revenue code billed. These Medicare crossover claims may also include specific services such as rehabilitation services, flu shots, and supplies. After Medicare payment is made, reimburse the I.H.S. and Tribal 638 facilities for the full co-insurance and deductible calculated by Medicare regardless of the service or revenue code used.

- For services provided to recipients with primary medical coverage by a third party, such as an insurer or other third party (excluding Medicare) who may be liable for the medical bill, Medicaid reimbursed the provider the Medicaid Inpatient or Outpatient OMB rate for that calendar year less the third-party payment.

- Services must be delivered in locations identified in Medicaid policy or locations that are consistent with professional standards of practice. Services locations outside the I.H.S. or Tribal 638 facilities may include locations such as nursing homes, schools, teen and wellness centers, chapter houses, homes, and non–I.H.S./Tribal 638 hospitals.
14 FAIR HEARINGS

Revision Dates: January 1, 2014
Review Date: January 1, 2014
Initial Effective Date: January 1, 2014

A. Administrative Hearings

Members can request an administrative hearing with the State in writing or orally from any HSD office i.e. local ISD office or MAD central office after exhausting the MCO’s grievance and appeal process. The administrative hearing must be requested within thirty (30) Calendar Days of the final grievance/appeal decision by the MCO.

The applicable HSD staff will provide notice of the request to the HSD Hearings Bureau. The HSD Hearings Bureau acknowledges receipt of the request and schedules the hearing. Once notice of the request is received by the HSD Hearings Bureau, the MCO will be notified of the hearing date and provided with relevant information on the member, including the identified issues.

MAD will maintain a log of all administrative hearing requests. The formal rules of evidence and civil procedure do not apply to the administrative proceeding. Relevant evidence is submitted and testimony is furnished during the proceeding in an orderly but less formal manner; however, the record created during the administrative hearing is a legal document which forms the basis for decisions made by the Court of Appeals if the member should seek redress from a court. The Court of Appeals is allowed to set aside the administrative decision only if it finds the decision to be arbitrary, capricious or an abuse of discretion, not supported by substantial evidence in the record as a whole, or otherwise not in accordance with the law.

Prior to the hearing, HSD and/or the MCO must submit a summary of evidence (SOE) that contains relevant demographic information, summary of issues, correspondence, etc. HSD will be responsible for completing the client demographic section of the summary and developing the summary of issues. The MCO will be responsible for submitting documentation concerning how and why the decision was made. The MCO is required to furnish the HSD Hearings Bureau with an “official record of the grievance and copy of the final MCO decision” within 5 business days of HSD’s request.

The HSD hearing officer may choose to hold an “agency conference”, the purpose of which is to informally review the MCO decision, determine whether issues can be resolved by mutual agreement and to clarify or define issues to be decided at the hearing. The Hearing Officer
appointed by the Bureau Chief of the HSD Hearings Bureau will determine where and how the administrative hearing will be conducted, in person or telephonically.

At the conclusion of the hearing, the Hearing Officer prepares a recommendation within 15 calendar days of the hearing which is reviewed by the Director of MAD. The final decision rests with the Director. Under federal law, the entire administrative process must be completed within 90 calendar days of the request for a hearing. Current state regulations require the process to be expedited and completed with 45 calendar days of the request for a hearing. The client and other involved parties are provided with notice of the Director’s final decision.

A client’s request for an administrative hearing which is received by HSD within 10 calendar days of the MCO final decision stays the enforcement of the MCO decision. The client or MCO has 30 calendar days to file an appeal of the Director’s decision with the clerk of the Court of Appeals and the HSD Office of General Counsel. Upon motion of the client or the MCO, the Court of Appeals decides whether filing of the appeal stays the enforcement of the MCO decision.

B. Summary of Evidence

One of HSD’s primary goals related to Fair Hearings is to develop and implement procedures that are consistent with HSD Fair Hearing rules and that will be practiced and adhered to by all parties involved. The following are focus points for process improvement:

- Timeliness in all phases of the process
- Maintain member confidentiality and protect PHI information
- Emphasize maintenance of complete and organized files
- Emphasize importance of documentation
- Accountability

The MCOs are key players in this process. Therefore, MCO participation to assist with process improvement is required. As part of this initiative, and in order to maintain organized and complete files, HSD/MAD is requesting that all MCOs use a standardized SOE form developed by the Department. Each SOE shall contain four (4) separate titled sections. Provide the information listed on each titled section of the SOE.
15 APPENDICES
A. APPENDIX A: NURSING FACILITY LEVEL OF CARE COMMUNICATION FORM
# Nursing Facility Level of Care Notification Form

## I. Nursing Facility Prior Authorization Request

### Nursing Facility Information

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Click here to enter a date</th>
<th>Type of Request</th>
<th>Choose an item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Name</td>
<td>Click here to enter text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NF Contact Name</td>
<td>Click here to enter text</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Facility Fax</td>
<td>Click here to enter text</td>
<td>Nursing Facility Phone</td>
<td>Click here to enter text</td>
</tr>
</tbody>
</table>

### Nursing Facility Resident Information:

<table>
<thead>
<tr>
<th>NF Resident Name</th>
<th>Click here to enter text</th>
<th>Resident DOB</th>
<th>Click here to enter text</th>
<th>Resident SSN#</th>
<th>xxx – xx –</th>
<th>Click here to enter text</th>
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</thead>
<tbody>
<tr>
<td>NF Admission Date</td>
<td>Click here to enter a date</td>
<td>Selected MCO</td>
<td>Choose an item</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Rep Name</td>
<td>Click here to enter text</td>
<td>Rep Phone</td>
<td>Click here to enter text</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident Rep Address</td>
<td>Click here to enter text</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Requesting Service

<table>
<thead>
<tr>
<th>NFLOC Type</th>
<th>Choose an item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Begin Date</td>
<td>Click here to enter a date</td>
</tr>
<tr>
<td>Service End Date</td>
<td>Click here to enter a date</td>
</tr>
</tbody>
</table>

### Documentation Requirements:

#### Initial Request:
- [ ] MDS
- [ ] Physician Order
- [ ] PASRR Level I and PASRR Level II if indicated by PASRR Level I
- [ ] History & Physical

#### Continuation Stay:
- [ ] Most recent MDS
- [ ] Physician Order within 60 days prior to the start date of the LOC
- [ ] Physician Progress Notes

## II. Utilization Management (For MCO Use Only)

### Review Information

<table>
<thead>
<tr>
<th>Date of Review</th>
<th>Click here to enter a date</th>
<th>Authorization Number</th>
<th>Click here to enter text</th>
</tr>
</thead>
<tbody>
<tr>
<td>NFLOC Begin Date</td>
<td>Click here to enter a date</td>
<td>NFLOC End Date</td>
<td>Click here to enter a date</td>
</tr>
<tr>
<td>Approved Bed Begin Date</td>
<td></td>
<td>Approved Bed End Date</td>
<td></td>
</tr>
</tbody>
</table>

### LNF Factors:

<table>
<thead>
<tr>
<th>Dressing</th>
<th>Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Mobility</td>
</tr>
<tr>
<td>Eating</td>
<td>Toileting</td>
</tr>
<tr>
<td>Meal Preparation</td>
<td>Bowel/Bladder</td>
</tr>
<tr>
<td></td>
<td>Daily Medication</td>
</tr>
</tbody>
</table>

### HNF Factors:

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>Rehabilitation Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation / Behavior</td>
<td>Skilled Nursing</td>
</tr>
<tr>
<td>Medication Administration</td>
<td>Feeding</td>
</tr>
<tr>
<td></td>
<td>Mobility / Transfer</td>
</tr>
</tbody>
</table>

Approved NFLOC Type: Choose an item.

Comments: Click here to enter text.
B. APPENDIX B: NURSING FACILITY NOTIFICATION FORM
## Nursing Facility Level of Care Communication Form

*This Communication Form is intended to be used between MCO and Nursing Facilities ONLY.*

### I. Requestor Information

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>FROM</th>
<th>Name</th>
<th>FROM Company</th>
<th>Fax</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Click here to enter a date.</td>
<td>Choose an item.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>TO</td>
<td>Name</td>
<td>TO Company</td>
<td>Fax</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Choose an item.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td></td>
</tr>
</tbody>
</table>

### II. Communication:

#### Nursing Facility Resident Information:

<table>
<thead>
<tr>
<th>NF Resident Name</th>
<th>Resident DOB</th>
<th>Resident SSN#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Click here to enter text.</td>
<td>Click here to enter text.</td>
<td>xxx – xx –</td>
</tr>
</tbody>
</table>

#### a. Request For Information

- Missing Member Demographics
- Missing MDS Required fields: Click here to enter text.
- MDS not within the service time frame requested
- Need a valid physician order for: Click here to enter text.
- Need member’s Level I PASSR
- Need member’s Level II PASSR
- Need current H&P (History & Physical completed within 6 months of the service request date)
- Need current signed and dated physician progress notes
- Medicare COB if applying therapy as HNF criteria for dual member
- Other: Click here to enter text.

#### b. Member Status Update

- Discharge Status
- Member Representative Info
- Current Progress Note
- Other: Click here to enter text.

#### c. Member MCO Update

- Member current MCO selection: Click here to enter text.
- Member previous MCO assignment: Click here to enter text.
C. APPENDIX C: SDCB RANGE OF RATES CHART
SDCB rates are to be provided to the MCOs by 5/31/13

<table>
<thead>
<tr>
<th>SDCB Service</th>
<th>Billing Code</th>
<th>Internal GCES Code</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker/Direct Support</td>
<td>99509</td>
<td>99509</td>
<td>Hour</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>S9122</td>
<td>S9122</td>
<td>Hour</td>
</tr>
<tr>
<td>Employment Supports (includes Job Coach)</td>
<td>T2019</td>
<td>T2019</td>
<td>15 min.</td>
</tr>
<tr>
<td>Job Developer (Per job that is developed for member)</td>
<td>T2019</td>
<td>T2019JD</td>
<td>Each</td>
</tr>
<tr>
<td>Customized Community Supports (adult day hab.)</td>
<td>S5100</td>
<td>S5100</td>
<td>15 min.</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>G0151</td>
<td>G0151</td>
<td>15 min.</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>G0152</td>
<td>G0152</td>
<td>15 min.</td>
</tr>
<tr>
<td>Speech/Language Pathology</td>
<td>G0153</td>
<td>G0153</td>
<td>15 min.</td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>H2019</td>
<td>H2019</td>
<td>15 min.</td>
</tr>
<tr>
<td>Private Duty Nursing – Adults- RN</td>
<td>T1002</td>
<td>T1002</td>
<td>15 min.</td>
</tr>
<tr>
<td>Private Duty Nursing – Adults- LPN</td>
<td>T1003</td>
<td>T1003</td>
<td>15 min.</td>
</tr>
<tr>
<td>Nutritional Counseling –Adults</td>
<td>S9470</td>
<td>S9470</td>
<td>Hour</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>97810</td>
<td>97810</td>
<td>15 min.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>90901</td>
<td>90901</td>
<td>Visit</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>98940</td>
<td>98940</td>
<td>Visit</td>
</tr>
<tr>
<td>Cognitive Rehab Therapy</td>
<td>97532</td>
<td>97532</td>
<td>15 min.</td>
</tr>
<tr>
<td>Hippotherapy</td>
<td>S8940</td>
<td>S8940</td>
<td>Visit</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>97124</td>
<td>97124</td>
<td>15 min.</td>
</tr>
<tr>
<td>Naprapathy</td>
<td>S8990</td>
<td>S8990</td>
<td>Visit</td>
</tr>
<tr>
<td>Native American Healers</td>
<td>S9445</td>
<td>S9445</td>
<td>Session</td>
</tr>
<tr>
<td>Play Therapy</td>
<td>H2032</td>
<td>H2032</td>
<td>15 min.</td>
</tr>
<tr>
<td>Respite Standard (not provided by RN, LPN or HHA)</td>
<td>T1005</td>
<td>T1005SD</td>
<td>15 min.</td>
</tr>
<tr>
<td>Respite RN</td>
<td>T1005</td>
<td>T1005RN</td>
<td>15 min.</td>
</tr>
<tr>
<td>Respite LPN</td>
<td>T1005</td>
<td>T1005LPN</td>
<td>15 min.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>SDCB Service</th>
<th>Billing Code</th>
<th>Internal GCES Code</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respite Home Health Aide</td>
<td>T1005</td>
<td>T1005HHA</td>
<td>15 min.</td>
</tr>
<tr>
<td>Emergency Response (monthly fee)</td>
<td>S5161</td>
<td>S5161</td>
<td>Each</td>
</tr>
<tr>
<td>Emergency Response (testing and maintenance)</td>
<td>S5160</td>
<td>S5160</td>
<td>Each</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td>S5165</td>
<td>S5165</td>
<td>Each</td>
</tr>
<tr>
<td>Transportation Time</td>
<td>T2007</td>
<td>T2007</td>
<td>Hour</td>
</tr>
<tr>
<td>Transportation Trip</td>
<td>T2003</td>
<td>T2003</td>
<td>Each</td>
</tr>
<tr>
<td>Transportation Mile</td>
<td>T2049</td>
<td>T2049</td>
<td>Per Mile</td>
</tr>
<tr>
<td>Transportation Commercial Carrier Pass</td>
<td>T2004</td>
<td>T2004</td>
<td>Each</td>
</tr>
<tr>
<td>Fees and Memberships</td>
<td>T1999</td>
<td>T1999CP-I</td>
<td>Each</td>
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<tr>
<td>Coaching/education for parents, spouse or others (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CE-I</td>
<td>Each</td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others-classes only (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CL-I</td>
<td>Each</td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others-conferences and seminars (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CS-I</td>
<td>Each</td>
</tr>
<tr>
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D. APPENDIX D: SDCB VENDOR CREDENTIALING REQUIREMENTS
Requirements for enrolling Self-Directed Community Benefit (SDCB) Vendors

Before using any Vendor, please call Xerox (1-866-916-0310) to make sure all required vendor paperwork has been processed and that the vendor has been set up on your SDCB Care Plan. If you use a vendor before their paperwork has been processed, they will not be paid for those dates.

All enrollment requirements (with the exception of the final criminal background check) must be processed before services can be provided. Services that are provided prior to enrollment will not be paid by Medicaid or Xerox.

If a vendor provides only goods (not services), you will only need to complete the Vendor Information Form (you do not need to complete the entire Vendor Packet). We use the Vendor Information Form (VIF) to show that you will be using this vendor on your Plan. Since vendors that provide goods are usually large companies (for example: CenturyLink, Comcast, Wal-mart, K-Mart, Best Buy), it is not necessary to get their signature on the form. If you are not sure if what you want to purchase is a “good” or a “service,” please call Xerox for assistance.

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<th>Service Code</th>
<th>Service Code Description</th>
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<th>Vendor Packet</th>
<th>License and/or Additional Requirements</th>
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<td>97810</td>
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<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<td></td>
<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
<td>IC: Yes</td>
<td>IC: Acupuncture and/or oriental medicine license</td>
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<td>Code</td>
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<td>H2019</td>
<td>Behavior Support Consultation</td>
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<tr>
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<td>IC: Yes</td>
<td>Licensed (MD, Clinical Psychologist, Psychologist Associate, SW, LPCC, LPC, Psychiatric Nurse, NM licensed marriage and family therapist, NM licensed art therapist)</td>
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<td>Biofeedback</td>
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<td>License in Health Care Profession whose scope of practice includes Biofeedback</td>
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<td>98940</td>
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| T2019JD       | Job Developer                       | Supported Employment       | Each     | Yes    | Yes | Agency: Business License

Provider Agency or Individual

Agency: Pre-Hire Packet
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<td>T1003</td>
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<td>--------</td>
</tr>
<tr>
<td>T1999CPEP</td>
<td>Cell Phone and Related Equipment Purchase (item)</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999IS</td>
<td>Internet Service</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999CELL</td>
<td>Cell Phone Service</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999LS</td>
<td>Landline Service</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999ICL</td>
<td>Internet/Cell Phone/Landline Service (bundled)</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999IC</td>
<td>Internet/Cell Phone Service (bundled)</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999IL</td>
<td>Internet/Landline Service (bundled)</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
<tr>
<td>T1999CPL</td>
<td>Cell Phone/Landline Service (bundled)</td>
<td>Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
</tr>
</tbody>
</table>
If the vendor has a professional license (such as a registered nurse or therapist), their licensing board has already completed a background check. They do not need to do another one for Mi Via. Provider agencies are responsible for completing criminal background checks (CBC) on all their staff. Confirmation of the CBC must be available to the State and Xerox for review as requested.

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Service Code Description</th>
<th>Billing Method</th>
<th>Vendor Packet</th>
<th>License and/or Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1999OS</td>
<td>Office Supplies (purchased as items)</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
<td></td>
<td>IC: Yes</td>
<td></td>
</tr>
<tr>
<td>T2004</td>
<td>Transportation Commercial Carrier Pass</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Transportation Commercial Carrier</td>
<td></td>
<td>IC: Yes</td>
<td></td>
</tr>
<tr>
<td>T2007</td>
<td>Transportation Time</td>
<td>Hourly</td>
<td>Agency: Yes</td>
<td>Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Transportation Agency or Individual Driver</td>
<td></td>
<td>IC: Yes</td>
<td>Transportation Appendix, Pre-Hire Packet</td>
</tr>
<tr>
<td>T2003</td>
<td>Transportation Trip</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Transportation Agency or Individual Driver</td>
<td></td>
<td>IC: Yes</td>
<td>Transportation Appendix, Pre-Hire Packet</td>
</tr>
<tr>
<td>T2049</td>
<td>Transportation Mile</td>
<td>Per Mile</td>
<td>Agency: Yes</td>
<td>Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Transportation Agency or Individual Driver</td>
<td></td>
<td>IC: Yes</td>
<td>Transportation Appendix, Pre-Hire Packet</td>
</tr>
</tbody>
</table>
Please remember that at the beginning of each SDCB Care Plan year (annual renewal), new Vendor Agreements are required for any vendor providing services. If ACS does not receive a Vendor Agreement before your new Plan starts, your vendor will not be set up on your new Plan and they may be paid late. Please call Xerox (1-866-916-0310) before your new SDCB Care Plan starts so you can make sure all your SDCB providers are set up for payment.

The above grid provides an overview of general vendor credentialing requirements. In certain specific cases, additional licensing or other documentation may be required.

Please contact Xerox (1-866-916-0310) or your Support Broker if you have any questions.
E. APPENDIX E: SDCB EMPLOYEE CREDENTIALING REQUIREMENTS
This table shows the enrollment paperwork that an employee MUST complete in order to provide these services.

<table>
<thead>
<tr>
<th>SELF-DIRECTED COMMUNITY BENEFIT SERVICE</th>
<th>Service Code</th>
<th>*Pre-Hire Packet</th>
<th>**Employee Packet</th>
<th>Transportation Appendix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Supports (includes Job Coach)</td>
<td>T2019</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Homemaker/Direct Support</td>
<td>99509</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Respite – Standard</td>
<td>T1005SD</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transportation Time</td>
<td>T2007</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transportation Mile</td>
<td>T2049</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Pre-Hire Packet: Division of Health Improvement (DHI) form, copy of identification card (ID), and three fingerprint cards.

**Employee Packet: Employee Information Form, Employee Agreement, Transportation Appendix (if performing driving services), Declaration of Relationship, W-4 (Federal and State), I-9 Form, Direct Deposit Authorization Form (optional).

HELPFUL REMINDERS
- Employer of Record (EOR) documentation must be completed and approved before an employee’s enrollment can be approved and before an employee can begin work.
- Employees may not begin working until they have passed their initial COR Background Check (this is included in the Pre-Hire Packet).
- Employees cannot be paid until their entire Employee Packet has been successfully processed.
- In order to drive, an employee must have current vehicle registration and insurance in the employee’s name.
- Please remember that Employees must complete a new Employee Agreement for each Plan year. If Xerox does not receive an Employee Agreement before the beginning of the new Plan, the employee may not get paid on time.
APPENDIX F: VENDOR PAYMENT REQUEST FORM
**Self-Direction PAYMENT REQUEST FORM**

The requested item and amount must be approved in your Support Plan and Budget. DO NOT use your own money to pay vendors. Xerox-FMA CANNOT reimburse you.

---

**ATTACH A VENDOR COST QUOTE OR VALID INVOICE WITH THIS PAYMENT REQUEST FORM**

Xerox, Inc.                                                                 Phone: 1-866-916-0310
P.O. Box 27460                                                                 FAX: 1-866-302-6787
Albuquerque, NM 87125

---

<table>
<thead>
<tr>
<th>Member/Participant Name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member/Participant Signature</td>
<td></td>
</tr>
<tr>
<td>Medicaid Card Number</td>
<td></td>
</tr>
<tr>
<td>Waiver Service Procedure Code/Modifier</td>
<td></td>
</tr>
<tr>
<td>Describe Item Being Purchased</td>
<td></td>
</tr>
<tr>
<td>Request Date</td>
<td></td>
</tr>
<tr>
<td>Full Payment Amount (including all taxes)</td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Payee Name (Vendor Name)</th>
<th>Vendor Federal Tax ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address Line 1

Address Line 2

City State Zip

---

**CHECKS WILL BE MAILED TO MEMBER/PARTICIPANT OR EMPLOYER OF RECORD**

Instructions:
1. “Request Date” and purchase must be within date of current approved SDCB budget
2. The “Waiver Service Procedure Code and Modifier” field must be filled in correctly
3. The request MUST BE APPROVED on the SSP Worksheet and Budget
4. Payment amount must include price of good or service and all applicable taxes
5. Submit a cost quote or Standard Invoice as required with this payment request form

---

Payment Request Form, 8/23/2013 v.1
G. APPENDIX G: VENDOR TOOLKIT
Toolkit: Invoices

Use these tips for completing Invoices!

Q: What is this toolkit for?

A: This toolkit explains how to make the invoice process work smoothly! Participants, Employers and Contractors can work together to help make sure invoices get processed and paid on time.

Keys to Getting Paid the Correct Amount, On Time!

Follow these tips to avoid delayed payment of your invoice.

- **Be sure ALL vendor paperwork has been completed and submitted.**

- **Effective July 15, 2011, invoices that are received by Xerox more than 90 days after the service was provided, will not be processed for payment.** According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the vendor performed the service. This means that all invoices must be submitted to Xerox no later than Midnight on the 90th day after services have taken place. **Any invoices that are submitted after this time limit will not be paid by Xerox and will be returned to you.** Also, if you need to make corrections to your invoice, you must complete them within this timeframe (90 days from the date the service was performed).

- **Follow the CURRENT Vendor Payment Schedule.**

  Keep a copy of the Vendor Payment Schedule in front of you. If you submit your invoice after the deadline on Saturday, your vendor payment may be delayed.

  **Note:** The **deadline** for submitting invoices is always on a Saturday by Midnight (before 12:00 am on Sunday).

- **Use your legally registered business name.**

  For example,
o Smith Industries, LLC is your legally registered business name with State of New Mexico. **This is the name you must use on your invoice!**

o Bobby Smith is your personal name. Do **not** use!

o Smith Wheelchair Repair is a name you sometimes use to refer to your company but it is not your legal name. Do **not** use!

- **Submit invoices for daily or monthly service codes after the service is complete.**
  
  Some service codes, for example T2033FL (Family Living), are for **daily** service. In this example, daily service means 24 hours. When submitting a service code such as this one, you must only sign, fax or email it after the day is complete. In other words, you must wait until Midnight of the day when services are delivered (after 11:59 PM) to submit the invoice. If the service is **monthly** you must wait until after 11:59 PM on the last day of the month. If the service is **hourly**, you must wait until you have finished working on that day. For example, if you finish working at 3:00 pm, you cannot submit your timesheet until 3:01 pm on the same day. The general rule is: you cannot enter, submit or sign an invoice for services not yet rendered.

- **Use correct units on invoices**
  
  For example, if the rate for service is in 15 minute increments, you must enter the invoice charge in 15 minute increments. Do not combine amounts into hourly.

- **Only the vendor can make a correction to an invoice**
  
  If the vendor needs to make a correction on their invoice, they can cross out the mistake and then write in the correction. They must also put their initials next to the correction. We will not accept invoices if white-out appears to have been used or if changes appear to have been made by anyone other than the vendor.

- **You can use your own invoice form, **but**…**
  
  Your invoice must include the same level and type of detail shown on the invoice (see below.) This detail is required for legal and auditing purposes and to ensure you get paid correctly and on time.

- **Send in the Payment Request Form (PRF)**
  
  The Payment Request Form (PRF) must also be submitted (in addition to the invoice). This applies whether it is you or the participant who typically sends in the PRF or faxes in the invoice. (The Participant is responsible for being sure that the PRF is sent in.)

- **Fax your invoice.**
  
  Only fax your invoice **one time** unless you are faxing a corrected invoice. If it is a corrected invoice, check the box **Yes** for “Is this a correction to a PRIOR
Invoice?” Re-faxing the same invoice or forgetting to check the “Corrected” box for a corrected invoice will cause delays in a check being issued. The fax number is 866-302-6787. This applies whether it is you or the participant who typically faxes in the invoice (the Participant is responsible for being sure that the invoice is faxed in).
### INVOICE FOR NON-TIMESHEET Provider Agency/Contractor

**FAX:** 1-866-302-6787  
**MAIL:** ACS PO Box 27460, Albuquerque, NM 87125  
**01/01/14**

Provider Agency/Contractor __Dr. John Doe________________________ Is this a correction to a PRIOR invoice?  ☐ Yes ☒ No

Date of Invoice (mm/dd/yyyy) __04/29/2011____________________ Total Invoice $ _81.06___________ *(must match total $ below)*

Participant Name: _____Pauline Participant_______________________ Participant Date of Birth: ____01/01/1975_________________

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Code</th>
<th>Hours per Day *</th>
<th>Rate per Hour *</th>
<th>Rate per Unit **</th>
<th># of Units **</th>
<th>Total Charge</th>
<th>What Service(s) were provided? Be specific.</th>
<th>Participant present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/25/11</td>
<td>G0151</td>
<td></td>
<td>$13.51</td>
<td>4</td>
<td>$54.04</td>
<td>Physical therapy</td>
<td>☒ Y ☐ N</td>
<td></td>
</tr>
<tr>
<td>4/28/11</td>
<td>G0151</td>
<td></td>
<td>$13.51</td>
<td>2</td>
<td>$27.02</td>
<td>Physical therapy</td>
<td>☒ Y ☐ N</td>
<td></td>
</tr>
</tbody>
</table>

This is the date the service was performed.  
Use your Plan to verify the correct service code.  
The Total Charge should always equal the # of Units x Rate.

| Total Hours | Total Units/Charge | 6 | $81.06 |
*Hours are entered for any service that is delivered hourly.

** A ‘UNIT’ is defined as a service that is delivered as a single item (each), per 15 minutes, daily, monthly, mile or visit/session.

Provider/Vendor Signature: ___ Dr. John Doe ___

Date ______04/29/2011_______________

Make sure the vendor signs here

Signature date must be on or after the last service date.

<table>
<thead>
<tr>
<th>Date</th>
<th>SVC Code</th>
<th>Hrs per Day</th>
<th>Rate per Hour</th>
<th>Rate per Unit</th>
<th>Units per Day</th>
<th>Total Charge</th>
<th>What Service(s) were provided? Be specific.</th>
<th>Participant present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>04-25-11</td>
<td>S9470</td>
<td>4</td>
<td>12.00</td>
<td></td>
<td></td>
<td>$48.00</td>
<td>Nutritional Counseling</td>
<td>Y □ N</td>
</tr>
<tr>
<td>04-26-11</td>
<td>T2049</td>
<td></td>
<td>0.034</td>
<td>50</td>
<td></td>
<td>$17.00</td>
<td>Mileage to the community center and back home.</td>
<td>Y □ N</td>
</tr>
<tr>
<td>04-27-11</td>
<td>T2033</td>
<td></td>
<td>25.00</td>
<td>1</td>
<td></td>
<td>$25.00</td>
<td>Customized In-Home Living Support</td>
<td>Y □ N</td>
</tr>
</tbody>
</table>

Total Hours 4

Total Units 51

$90.00

This form MUST be attached to the Payment Request Form (PRF) for all services.
Q: What is this toolkit for?

A: This toolkit explains how to make the timesheet process work smoothly! Participants, Employers and Employees can work together to help make sure timesheets get processed and paid on time.

**TIPS FOR GETTING PAYCHECKS THAT ARE ACCURATE AND ON TIME!**

- **Be sure ALL employee paperwork has been completed & submitted.**

- **Effective January 1, 2014, timesheets that are received by Xerox more than 90 days after the service was provided will not be processed for payment.** According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the employee worked. This means that all timesheets must be submitted to Xerox (via fax or the FOCoS online system) no later than Midnight on the 90th day after services have taken place. Any timesheets that are submitted after this time limit will not be paid by Xerox and will be returned to you. Also, if you need to make corrections to your timesheets, you must complete them within this timeframe (90 days from the date the employee worked).

- **Follow the CURRENT payroll periods.**

  Keep a copy of the payroll schedule in front of you. Timesheets submitted after Saturday’s deadline may result in a delayed paycheck. If you would like a copy of the current Payroll Payment Schedule, please contact the Xerox Help Desk (1-866-916-0310).

  **Note:** The **deadline** for submitting timesheets is always on a Saturday by Midnight (before 12:00 am on Sunday).

- **Service dates on all timesheets need to be ON or BEFORE the last day of the timesheet period.**

  You cannot enter, submit or sign a timesheet for work not yet performed. For example, if the pay period ends on Friday, May 20th, you cannot enter time for services you will provide on Monday, May 23rd even if the services are generally similar or the same.
- **Services Provided-field on the Timesheet.**
  Enter descriptions of tasks and services provided to the Participant.

- **Timesheets need to be complete and correct** (see example on Page 3 of this toolkit).

- **Both the Employee and the Employer need to sign and date the timesheet.**

- **Fax your timesheet.**
  Only fax your timesheet **one (1) time** unless you are faxing a corrected timesheet **or** if you have been asked to refax it. If it is a corrected timesheet, check the box **Yes** for “Is this a correction to a PRIOR Timesheet?” Not following these guidelines can cause delays in a check being issued. **The fax number is 866-302-6787.**

- **Use the exact same name on your timesheet as used for your employee paperwork.**
  For example, if you completed paperwork as William J Smith and you enter Billy Smith on your timesheet, we won’t know who you are. This will cause a delay in getting paid.

Self-Directed
## 2-Week Self-Directed Timesheet for Payment

**Employee Name:** Ellie Employee  
**Employee ID# (last 4 digits of employee's social security #):** 1234

**Participant:** Pauline Participant

**Participant’s Date of Birth:**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Hours</th>
<th>Service Code</th>
<th>Services Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/07/2011</td>
<td>AM 8:00</td>
<td>PM</td>
<td>3</td>
<td>99509</td>
<td>Prepared meals, shopped for groceries.</td>
</tr>
<tr>
<td></td>
<td>AM 11:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/08/2011</td>
<td>AM 8:00</td>
<td>PM</td>
<td>3</td>
<td>99509</td>
<td>Picked up Pauline’s prescriptions at pharmacy, helped her with laundry.</td>
</tr>
<tr>
<td></td>
<td>AM 11:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/09/2011</td>
<td>AM 8:00</td>
<td>PM</td>
<td>3</td>
<td>99509</td>
<td>Helped Pauline pack for trip to visit brother.</td>
</tr>
<tr>
<td></td>
<td>AM 11:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/10/2011</td>
<td>AM 10:00</td>
<td>PM</td>
<td>2</td>
<td>99509</td>
<td>Cleaned apartment.</td>
</tr>
<tr>
<td></td>
<td>AM 12:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/11/2011</td>
<td>AM 12:00</td>
<td>PM</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AM 1:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/14/2011</td>
<td>AM 10:00</td>
<td>PM</td>
<td>2</td>
<td>99509</td>
<td>Laundry, cleaned apartment.</td>
</tr>
<tr>
<td></td>
<td>AM 12:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/15/2011</td>
<td>AM 12:00</td>
<td>PM</td>
<td>3</td>
<td>99509</td>
<td>Teach Pauline how to use computer.</td>
</tr>
<tr>
<td></td>
<td>AM 3:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/16/2011</td>
<td>AM 2:00</td>
<td>PM</td>
<td>6</td>
<td>99509</td>
<td>Worked with Pauline on practicing better safety skills at home.</td>
</tr>
<tr>
<td></td>
<td>AM 8:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/17/2011</td>
<td>AM 8:00</td>
<td>PM</td>
<td>8</td>
<td>99509</td>
<td>Worked with Pauline on washing dishes and cleaning the apartment.</td>
</tr>
<tr>
<td></td>
<td>AM 4:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/18/2011</td>
<td>AM 8:00</td>
<td>PM</td>
<td>5</td>
<td>99509</td>
<td>Prepared frozen meals for next week.</td>
</tr>
<tr>
<td></td>
<td>AM 1:00</td>
<td>PM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Hours for Week 1:** 18  
**Must not be over 40**

**Total Hours for Week 1 + Week 2**

### Midnight Rule
10PM-12AM (1st day)

### Split Shift
8AM – 11AM Homemaker/Direct Support Services

**Signed & dated on or after last service date**
<table>
<thead>
<tr>
<th>Total Hours for Timesheet (2 weeks)</th>
<th>42</th>
<th>Must not be over 80</th>
</tr>
</thead>
</table>

| Ellie Employee | 24 | Must not be over 40 |

| Total Hours for Week 2 | 24 |

<table>
<thead>
<tr>
<th>Employee Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellie Employee</td>
<td>5/21/2011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pauline Participant</td>
<td>5/21/11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employee Printed Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ellie Employee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employer Printed Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pauline Participant</td>
</tr>
</tbody>
</table>
I. APPENDIX I: EMPLOYER OF RECORD (EOR) SELF-ASSESSMENT
TO: CENTENNIAL CARE MANAGED CARE ORGANIZATIONS
FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION
THROUGH: CATHY ROCKE, CHIEF, CENTENNIAL CARE BUREAU
BY: CRYSTAL HODGES, STAFF MANAGER, CENTENNIAL CARE BUREAU
SUBJECT: FORM MAD 614, CENTENNIAL CARE SELF-DIRECTED COMMUNITY BENEFIT EMPLOYER OF RECORD (EOR) SELF-ASSESSMENT

MANUAL REVISION

The MAD 614-Centennial Care Self-Directed Community Benefit Employer of Record (EOR) Self-Assessment has been developed in compliance with the Centennial Care Medicaid Managed Care Services Agreement, section 4.6.5-Self-Assessment.

Centennial Care Contractors shall provide each member with a self-assessment instrument developed by HSD. The self-assessment instrument shall be completed by the member with the assistance from the member’s care coordinator as appropriate. The Care coordinator shall file the completed self-assessment in the member’s file. If, based on the results of the self-assessment, the care coordinator determines that a member requires assistance to direct his or her services, the care coordinator shall inform the member that he or she will need to designate either an EOR or an Authorized Agent to assume the self-direction functions on the member’s behalf.

This form is to be used for Centennial Care Self Direction Community Benefit effective January 1, 2014 and filed by the MCO in each member’s file.

Please address questions concerning this form to orlando.vasquez@state.nm.us or call 505-827-6264 or teresaj.garcia@state.nm.us or call (505) 476-7256.

Attachments
Form MAD 614
In order to be an employer of record (EOR) in the Centennial Care Self-Directed Community Benefit (SDCB), a member must meet the following qualifications:

1. The member must not be a minor (under 18 years old); and
2. The member must have the legal authority to enter into a contractual agreement with his/her employees and vendors. The member must not have a plenary guardianship or conservatorship in place.

Employer of Record (EOR) responsibilities include:

1. Arranging for the delivery of services, supports and goods as approved in the care plan;
2. Verifying and attesting that employees meet the minimum qualifications for employment as required by the SDCB;
3. Orienting, training, and directing employees in providing the services that are described and authorized in the member’s care plan;
4. Establishing a mutually agreeable schedule for employees’ services in writing and providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;
5. Submitting all required documents to the FMA. Documents must be completed and provided to the FMA according to the timelines and rules established by the State. Documents include, but are not limited to, vendor and employee agreements, vendor information forms, criminal background check forms, time-sheets, payment request forms (PRFs) and invoices, updated employee information, and other documentation needed by the FMA to process payment to employees and vendors;
6. Agreeing that employees may not begin work until all materials necessary for a criminal background check have been received by Xerox and the employee has successfully passed the Consolidated Online Registry (COR) Background Check.
7. Agreeing to select or employ the employee on an interim (temporary) basis until a final criminal history record check has been completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3. The employer discusses this with the employee and reserves the right to dismiss the employee based on the results of the criminal history record check.
8. Providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;
9. Authorizing completed employee timesheets in order to pay employees according to the predetermined payroll schedule. Net wages will include gross earnings calculated according to the employee’s pay rate, minus payroll deductions for the employee’s share of applicable state, federal, and local payroll withholdings;
10. Reporting any incidents of abuse, neglect or exploitation by any employee or other service provider to the MCO/care coordinator;
11. Maintaining employee and service records and documentation in accordance with SDCB rules and Federal and State employment rules;
12. Fully cooperating with the NM Department of Workforce Solutions (DWS) in any investigations or other matters related to his/her employees;
13. Fully cooperating with the State’s worker’s compensation carrier, currently NM Mutual. Responsibilities include reporting claims and providing information to NM Mutual;
14. Meeting Federal employer requirements, such as completing and maintaining a Federal I-9 form for each employee as required by law; and
15. When necessary, requesting assistance from the care coordinator/support broker with any of these responsibilities.
Centennial Care Self-Directed Community Benefit
Employer of Record (EOR) Self-Assessment

This form is to be completed by the Self-Directed Community Benefit (SDCB) member and care coordinator or support broker and submitted to the managed care organization (MCO) upon annual care plan renewal or upon selecting the SDCB.

Member Name ________________________________

Member Date of Birth __________________________

Member ID# _________________________________

Managed Care Organization ________________________

Name of Care Coordinator and signature _________________

Name of Support Broker and signature _________________

Name of Support Broker Agency (if applicable) ________________

Date ______________________________________

To determine if the member can be his/her own EOR:

Is the member a minor? ________________ (If yes, the member cannot be his/her own EOR and must select an EOR, do not answer the questions below.)

Does the member have a plenary guardianship or conservatorship in place? ________________ (If yes, the member cannot be his/her own EOR and must select an EOR, do not answer the questions below)

Does the member have a power of attorney (POA) in place? ________________ (If yes, the MCO must obtain a copy of the POA and verify that it allows for the member to legally enter into contractual relationships and perform all functions of an EOR). Please list the name of the power of attorney and his/her relationship to the member __________________________

Additional questions:

Has the member received training on how to approve and submit timesheets through GCES? __________

Does the member currently approve and submit timesheets electronically through GCES? __________ If no, please explain why:

Do any of the member's current employees or vendors have power of attorney for the member? __________ If yes, please list the name(s) of the employees.
Does the member need assistance with any of the EOR responsibilities listed on page 1 of this form?

If yes, which ones?

Who will provide assistance?

Does the member understand the responsibilities of an EOR?

Does the member want to be his/her own EOR? If no, who has the member selected to be his/her EOR? (Include relationship to the member)

Member signature

To be completed by the MCO

___ The member is approved to serve as his/her own EOR

___ The member is not approved to serve as his/her own EOR

Upon completion, a copy of this form must be sent to the FMA and a copy must be maintained in the member’s file.
Centennial Care Self-Directed Community Benefit (siglas en inglés SDCB)
Beneficio de la Comunidad de Cuidado del Centenario Auto – Dirigido

Employer of Record (siglas en inglés EOR) Self - Assessment
Auto-Evaluación del Empleador de Empleado de Récord.

Para ser un employer of record siglas en inglés (EOR) del Centennial Care Self - Directed Community Benefit (siglas en inglés SDCB) un miembro debe tener las siguientes calificaciones:

1. El miembro no debe ser un menor de edad( menor de 18 años) y
2. El miembro debe tener autoridad legal para entrar en un acuerdo contractual con sus empleados y vendedores. El miembro no debe estar bajo custodia con plenos poderes ni protección legal activa.

Las responsabilidades de un EOR incluyen:

1. Arreglar la entrega de servicios, apoyo y bienes según lo aprobado por el plan de cuidado;
2. Verificar y dar fe que los empleados cumplan con las calificaciones mínimas de empleo según los requerido por SDCB;
3. Orientar, entrenar y dirigir a los empleados en proporcionar servicios que describen y autorizan la membrecía del plan de cuidado;
4. Establecer de común acuerdo un horario, por escrito, para los servicios de los empleados y anunciar con el tiempo suficiente si hubiere cambios en el horario de trabajo del empleado en caso de circunstancias imprevistas o emergencias;
5. Remitir los documentos requeridos al FMA. Los documentos deben ser completados y proporcionados a FMA de acuerdo con los plazos y regulaciones establecidas por el estado. Los documentos incluyen, pero no se limita a: acuerdos entre vendedor y empleado; formularios de información del vendedor; formularios de chequeo de antecedentes criminales; hojas de tiempo trabajado, formularios de requerimiento de pagos (PRFS) y facturas, información al día del empleado, y otra documentación requerida por FMA para procesar el pago a vendedores y empleados.
6. Estar de acuerdo que los empleados no comenzarán a trabajar hasta que los materiales necesarios sobre los antecedentes criminales se hayan recibido fotocopiados y que el empleado haya pasado con éxito el Consolidated Online Registry (siglas en inglés COR) del chequeo de antecedentes.
7. Estar de acuerdo en seleccionar o emplear a un individuo como un empleado interino (temporal) hasta que el chequeo de su historial criminal se haya completado, y para aquellos con delitos que determinen convicciones que descalifiquen al individuo como lo señala el NMSA 1978, en la sección 29-17-3. El empleador discute esto con el empleado y se reserva el derecho de despedir al empleado basado en los resultados del chequeo del historial de antecedentes criminales;
8. Proporcionar una notificación con la anticipación debida sobre los cambios del horario de trabajo del empleado en el caso de circunstancias imprevistas o emergencias;
9. Autorizar las hojas completas de tiempo trabajado para pagar a los empleados de acuerdo con el horario de pagos predeterminado. El salario neto debe incluir el salario bruto calculado de acuerdo a la tasa de pago del empleado, menos las deducciones por planilla que está sujeto el empleado por retenciones federales y locales.
10. Reportar todo incidente de abuso, falta de cuidado o explotación por parte de cualquier empleado u otro proveedor de servicios al coordinador de cuidado MCO.
11. Mantener récords de los empleados y de los servicios y toda la documentación de acuerdo con las reglas de SDCB y las reglas de empleo federales y estatales.

12. Cooperar completamente con NM Department of Workforce Solutions (siglas en inglés DWS) en cualquier investigación u otras materias relacionadas con sus empleados;

13. Cooperar completamente con el agente portador de compensación para trabajadores del estado, actualmente NM Mutual. Las responsabilidades incluyen el reporte de reclamaciones y proporcionar la información a NM Mutual;

14. Cumplir con los requisitos de los empleados federales, tales como completar y mantener el formulario I-9 para cada empleado, como lo requiere la ley; y

15. Cuando sea necesario, solicitar asistencia del agente de apoyo y coordinador de cuidado con cada una de estas obligaciones.
Centennial Care Self-Directed Community Benefit (siglas en inglés SDCB)
Beneficio de la Comunidad de Cuidado del Centenario Auto – Dirigido

Employer of Record (siglas en inglés EOR) Self - Assessment
Auto-Evaluación del Empleador de Empleado con Registro.

Este formulario debe completarse por el miembro de SDCB, o coordinador de cuidado o agente de apoyo y remitirlo a una organización del cuidado de la salud (MCO) para el cuidado anual o para seleccionar SDCB.

Nombre y Apellidos del Miembro ___________________________
Fecha de Nacimiento del Miembro ___________________________
Identificación del Miembro ________________________________
Organización del Cuidado de la Salud _________________________
Nombre y Apellidos del Coordinador de Cuidado y Firma __________________________
Nombre y Apellidos del Agente de Apoyo y Firma __________________________
Fecha __________________________

Para determinar si el miembro puede ser su propio EOR

¿Es el miembro menor de edad? ____________ (Si la respuesta es Sí, el miembro no puede ser su propio EOR y debe seleccionar un EOR. No conteste las otras preguntas)

¿Está el miembro bajo custodia con plenos poderes o protección legal activa? ____________ (Si la respuesta es Sí, el miembro no puede ser su propio EOR y debe seleccionar un EOR. No conteste las otras preguntas)

¿Ha otorgado el miembro un poder absoluto activo? ____________ (Si la respuesta es Sí, el MCO puede obtener una copia del poder absoluto activo y verificar si el miembro tiene la autorización para contraer relaciones contractuales y asumir todas las funciones de un EOR) Por favor, escriba el nombre de la persona con el poder absoluto activo y la relación que esta persona tiene con el miembro.

Preguntas Adicionales

¿Ha recibido el miembro entrenamiento sobre cómo aprobar o remitir las hojas de horas trabajadas a través de GCES? __________________________

¿Ha aprobado y remitido, actualmente, el miembro hojas de horas trabajadas electrónicamente a través de GCES? Si la respuesta es NO, por favor explique por qué __________________________
¿Tiene algún miembro de los actuales empleados o vendedores un poder absoluto activo del miembro? Si la respuesta es SÍ, por favor haga una lista de los nombres y apellidos de los empleados.

¿Algun miembro necesita asistencia con cualquiera de las obligaciones de EOR enumeradas en la página 1 de este formulario? Si su respuesta es SÍ, explique cuáles?

¿Quién le proporcionará la asistencia?

¿Entiende el miembro las obligaciones de un EOR?

¿Desea el miembro ser su propio EOR? Si su respuesta en NO, a quién ha seleccionado el miembro para su EOR (incluya la relación que existe con el miembro).

Firma del miembro

Para ser completado por el MCO

___ el miembro ha sido aprobado para ser su propio EOR

___ el miembro no ha sido aprobado para ser su propio EOR

Una vez que haya completado este formulario, una copia de éste debe ser enviada a FMA y una copia debe permanecer en el archivo del miembro.
J. APPENDIX J: LIST OF SDCB ACRONYMS AND SERVICES
List of Acronyms

**SELF-DIRECTED COMMUNITY BENEFIT**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Authorized Agent</td>
</tr>
<tr>
<td>CBC</td>
<td>Criminal Background Check</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare/Medicaid Services</td>
</tr>
<tr>
<td>CNA</td>
<td>Comprehensive Needs Assessment</td>
</tr>
<tr>
<td>COR</td>
<td>Central On-line Registry</td>
</tr>
<tr>
<td>EOR</td>
<td>Employer of Record</td>
</tr>
<tr>
<td>FMA</td>
<td>Financial Management Agency</td>
</tr>
<tr>
<td>HSD</td>
<td>Human Services Department</td>
</tr>
<tr>
<td>LRI</td>
<td>Legally Responsible Individual</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed Care Organization</td>
</tr>
<tr>
<td>MCO/UR</td>
<td>Managed Care Organization/Utilization Review</td>
</tr>
<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>LOC</td>
<td>Level of Care</td>
</tr>
<tr>
<td>QA/QI</td>
<td>Quality Assurance/Quality Improvement</td>
</tr>
<tr>
<td>PRF</td>
<td>Payment Request Form</td>
</tr>
<tr>
<td>SB</td>
<td>Support Broker</td>
</tr>
<tr>
<td>SDCB</td>
<td>Self-Directed Community Benefit</td>
</tr>
<tr>
<td>SLP</td>
<td>Speech Language Pathologist</td>
</tr>
</tbody>
</table>
Self-Directed Community Benefits

Behavior Support Consultation Services
Customized Community Supports
Employment Supports
Emergency Response
Environmental Modification
Home Health Aide
Homemaker
Nutritional Counseling
Private Duty Nursing
Related Goods
Respite
Skilled Therapy Services for Adults
Specialized Therapies
Transportation (non-medical)
Recipient Definitions

Note that there are 2 kinds of ABP recipients:

- **ABP recipient:** the recipient is category of eligibility 100, but does not have a disability indicator of PH or ME. The charts below are only applicable to the ABP recipient category.

- **ABP Exempt:** the recipient is category of eligibility 100 but also has a disability indicator of PH or ME, meaning either a physical health or mental health disability or other condition that qualifies the recipient as medically frail.

When an ABP recipient’s condition is evaluated and it is determined they meet the qualifying conditions, they may choose to become an “ABP Exempt” recipient. The benefit package of an “ABP Exempt” recipient changes from the standard ABP recipient to that of the “standard” Medicaid full benefit recipient. That is, the ABP benefit package ends, and the ABP Exempt recipient then has access to the same benefits as a full standard Medicaid recipient.

Their category of eligibility of the recipient remains 100 with a PH or ME indicator to distinguish them in the various computer systems.

- Because the benefits of an ABP- Exempt recipient become the same as any other standard full benefit Medicaid recipient, we do not list their benefits in this chart.

The term “ABP recipient” always means an ABP recipient who is NOT ABP exempt. If the recipient is exempt, and therefore eligible for the standard Medicaid full benefit services, the recipient is always referred to as an “ABP Exempt recipient”.

Once the recipient becomes a ABP Exempt recipient, he or she are NOT subject to any of the service limits associated with ABP. They do not retain any of the additional services that are found only in the ABP (primarily preventive services.). If the ABP Exempt recipient is enrolled in an MCO, the MCO extends the same benefits and managed care services to the ABP Exempt recipient that are provided to the full benefit Medicaid recipient.
1. AN ABP RECIPIENT HAS THE FOLLOWING BENEFITS EQUIVALENT TO THOSE OF STANDARD MEDICAID BENEFITS:

Professional Services and Treatments, including Services at FQHC’s and other clinics; Inpatient and outpatient hospital Services; Equipment and Devices; Laboratory and Radiology; and Transportation

The coverage of the following services or providers of services under the Alternative Benefit Plan is essentially the same as exists for the standard Medicaid full benefit population and, therefore, would be covered by a managed care organization (MCO) to the same extent that an MCO covers and provides services to traditional full Medicaid eligible recipients.

The lists below are intended to be used to communicate the general scope of the services. Not every provider and service is described:

a. Physician and most practitioner services and visits, including maternity service, surgeries, anesthesia, podiatry, etc., that are available for traditional full Medicaid eligible recipients.

b. Behavioral health and substance abuse services, evaluations, assessments, therapies, including all the various forms of therapy such as CCSS that are available for traditional full Medicaid eligible recipients.

- **Specialized BH services for children:** the MCO must assure that BH and substance abuse services provided to EPSDT recipients are available to ABP recipients ages 19 and 20

- **Specialized BH services for adults:** The specialized behavioral health services for adults are Intensive Outpatient (IOP), Assertive Community Treatment (ACT), and Psychosocial Rehabilitation (PSR). These 3 services are included in the ABP.

- **Services not included in the ABP:** The following services are not included in the ABP plan because they are considered more in the area of supportive waiver-type services and are not state plan services: Family Support, Recovery Services, and Respite Services.
• **Electroconvulsive therapy**: Note this is a benefit under ABP but not as state plan service for standard service.

c. Cancer trials, chemotherapy, IV infusions, and reconstructive surgery services that are available for traditional full Medicaid eligible recipients.

d. Dental services as available for traditional full Medicaid eligible recipients. An EPSDT recipient must have available the increased frequency schedule of oral exams every six months and orthodontia (when medically necessary) for 19 and 20 year olds per EPSDT rules.

e. Diabetes treatment including diabetic shoes.

f. Dialysis

g. Durable medical equipment, oxygen, and supplies necessary to use other equipment such as for oxygen equipment, ventilators and nebulizers, or to assist with treatment such as casts and splints that are applied by the healthcare practitioner.

h. Family planning, sterilization, pregnancy termination, contraceptives

i. Hearing testing or screening as part of a routine health exam but note that ABP does not cover the hearing aids so would not typically cover audiologist’s services or any services by a hearing aid dealer, except for EPSDT children, ages 19 and 20, for whom testing and hearing aids are covered.

j. Hospice: If the hospice recipient requires NF level of care, the recipient will have to meet the requirements for receiving NF care.

k. Hospital inpatient, outpatient, urgent care, emergency department, outpatient free-standing psych hospitals, inpatient units in acute care hospitals for rehabilitation or psychiatric, and rehabilitation specialty hospitals.

• Note that free-standing psych hospitals are only covered for EPSDT children (therefore, up through age 20) for fee for service recipients. However, managed care organizations continue to pay for inpatient free-standing psych hospitals for adults.
• Inpatient drug rehab services are not an ABP benefit. Acute inpatient services for “detox” are an ABP covered benefit.

l. Immunizations, mammography, colorectal cancer screenings, pap smears, PSA tests, and other age appropriate tests that are available for traditional full Medicaid eligible recipients.

m. Inhalation therapy

n. Lab including diagnostic testing, and colorectal cancer screenings, pap smears, PSA tests, and other age appropriate tests that are available for traditional full Medicaid eligible recipients.

o. Lab genetic testing to specific molecular lab tests such as BRCA 1 and BRCA 2 and similar tests used to determine appropriate treatment, not including random genetic screening.

p. Medication assisted treatment (substance abuse treatment including methadone programs, naloxone, and suboxone)

q. Ob-gyn, prenatal care, deliveries, midwives

r. Orthotics (note foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes)

s. Podiatry services are available to the same extent as for traditional full Medicaid eligible recipients. (coverage is similar to Medicare).

t. Prescription drug items (but not over the counter items, except for prenatal drug items (examples –vitamins, folic acid; iron), low dose aspirin as preventative for cardiac conditions; contraception drugs and devices, and items for treating diabetes. OTC items are covered for ages 19 and 20).

u. Prosthetics are available to the same extent as for traditional full Medicaid eligible recipients.

v. Radiology including diagnostic imaging and radiation therapy, including mammography and other age appropriate imagining.

w. Reproductive health services are available to the same extent as for traditional full Medicaid eligible recipients.
x. Telemedicine

y. Tobacco cessation counseling that are available for traditional full Medicaid eligible recipients. (note however, that MCO must cover tobacco cessation counseling beyond the Medicaid fee for service coverage)

z. Transportation (emergency and non-emergency) including air and ground ambulance, taxi and handivan

The following services are not covered under the standard Medicaid benefits or the ABP and therefore are not required to be covered by the MCO for ABP members unless the MCO chooses to do so as value added services.

- Acupuncture
- Infertility treatment
- Naprapathy
- Temporomandibular joint (TMJ) and cranial mandibular joint (CMJ) treatment
- Weight loss programs
- Any other service not covered by the standard Medicaid program unless specifically described as an added benefit for ABP in section 3, below.

Note also that the ABP does not include the following:

- Community benefits
- Nursing facility care, except as a temporary step down level of care from a hospital prior to being discharged to home
- Mi Via

However, if an ABP recipient becomes an ABP Exempt recipient, the recipient can access community benefits, nursing facility care, and Mi Via when all the requirements to receive those services are met.
2. AN ABP RECIPIENT HAS THE FOLLOWING BENEFITS SIMILAR TO STANDARD MEDICAID RECIPIENTS BUT WITH LIMITATIONS:

These are services which are benefits for recipients under the standard Medicaid program but which have limitations to coverage under the ABP.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE</th>
<th>FOR AGES 19 AND 20 LIMITATIONS DO NOT APPLY TO ABP RECIPIENTS (COE 100) who are ages 19 or 20 because of EPSDT rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric surgery</td>
<td>Limited to 1 per life time.</td>
<td>Covered under EPSDT if medically necessary (perhaps unlikely) without the life time limit.</td>
</tr>
<tr>
<td></td>
<td>Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.</td>
<td>Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Limited to 36 hours per cardiac event</td>
<td>Covered under EPSDT if medically necessary without the limit on hours.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Not covered</td>
<td>Covered under EPSDT if medically necessary (this very rarely happens)</td>
</tr>
<tr>
<td>Drug items that do not require a prescription (OTC)</td>
<td>Not covered</td>
<td>Covered using the same provisions as for recipient under EPSDT in the standard Medicaid program.</td>
</tr>
<tr>
<td></td>
<td>- except for items that are related to prenatal care; low dose aspirin for preventing cardiac events; treatment of diabetes, items used for contraception (foams, devices, etc.)</td>
<td>Note that coverage of diabetic test strips, and similar items are</td>
</tr>
<tr>
<td>SERVICE</td>
<td>LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE</td>
<td>FOR AGES 19 AND 20 LIMITATIONS DO NOT APPLY TO ABP RECIPIENTS (COE 100) who are ages 19 or 20 because of EPSDT rules</td>
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<tr>
<td>-------------------------</td>
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<td>---------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>described under medical supplies, below.</td>
<td>Recipients under age 19 are not enrolled in ABPEC</td>
</tr>
<tr>
<td></td>
<td>Note that an MCO may choose to cover any over the counter product when the over the counter product is less expensive that the therapeutically equivalent drug that would require a prescription (a “legend” drug.)</td>
<td></td>
</tr>
<tr>
<td>Glasses and contact lens</td>
<td>Not covered except for aphakia (following removal of the lens.)</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program.</td>
</tr>
<tr>
<td></td>
<td>Note that eye exams and treatment related to eye diseases and testing for eye diseases are a benefit, but that the refraction component of the exam (a separate code) is not a benefit.</td>
<td></td>
</tr>
<tr>
<td>Hearing aids</td>
<td>Not covered.</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program.</td>
</tr>
<tr>
<td></td>
<td>Note that hearing screening is covered but only when part of a routine health exam. Typically additional separate payment is not made for this part of the exam.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing testing by an audiologist or a hearing aid dealer is not a benefit.</td>
<td></td>
</tr>
<tr>
<td>Home health services</td>
<td>Limited to 100 visits annually – a</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered under EPSDT without the limitation on the dollar</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE</td>
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</tr>
<tr>
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<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical foods for errors of inborn metabolism, or as a substitute for other food for weight gain, weight loss, or specialized diets, for use at home by a recipient.</td>
<td>Not covered.</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.</td>
</tr>
<tr>
<td>Disposable medical Supplies - such as diapers, under pads, gauzes, gloves, dressings, colostomy supplies, for use at home by a recipient.</td>
<td>Not covered, -except for diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.) However supplies necessary to utilize oxygen or DME such as administer oxygen, use nebulizer, clean tracheas for ventilator use, or assist in treatments such as casts or splints are covered. Medical supplies used on an inpatient basis, applied as part of a treatment in a practitioner’s office, outpatient hospital, residential facilities, as a home health service, etc are covered.</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.</td>
</tr>
<tr>
<td>visit cannot exceed 4 hours. An MCO has the option of providing these services through private duty nursing and nursing registry personnel.</td>
<td>amount or length of visits.</td>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE</td>
<td>FOR AGES 19 AND 20 LIMITATIONS DO NOT APPLY TO ABP RECIPIENTS (COE 100) who are ages 19 or 20 because of EPSDT rules</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>though often these items are not paid separately in addition to the payment for the overall service. When separate payment is allowed in these settings, the items are considered covered.</td>
<td>Recipients under age 19 are not enrolled in ABPEC</td>
</tr>
<tr>
<td>Pulmonary rehab</td>
<td>Limited to 36 hours per year</td>
<td>Covered under EPSDT without the limitation on the number of visits.</td>
</tr>
<tr>
<td>Rehabilitation and Habilitation</td>
<td>Rehabilitative services for short-term physical, occupational, and speech therapies are covered. Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment. Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, dependent on the approval of the MCO’S medical director, only if such services can be expected to result in continued significant improvement of the member’s physical condition within the extension period. Other than the above one-time extension, therapy services</td>
<td>Covered under EPSDT without the limitation on duration.</td>
</tr>
<tr>
<td>- Physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Occupational therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speech and language pathology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SERVICE | LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE | FOR AGES 19 AND 20
--- | --- | ---
|  | extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered. | LIMITATIONS DO NOT APPLY TO ABP RECIPIENTS (COE 100) who are ages 19 or 20 because of EPSDT rules. Recipients under age 19 are not enrolled in ABPEC. |
| Extended care hospitals (long term care hospitals) | Extended care hospitals are not covered. Sometimes these are referred to as long term care hospitals (certified as acute care hospitals but focus on care for more than 25 days). NF long term care stays are not covered by ABP except as a temporary step down level of care following discharge from a hospital prior to being discharged to home. Refer to page 4 for more information. | Covered under EPSDT without the limitations. |
| Sleep studies | Not covered | Covered under EPSDT |
| Transplants | Limited to 2 per lifetime | Covered under EPSDT without the dollar amount limitation. |

### 3. ABP BENEFITS THAT MAY EXCEED THE STANDARD MEDICAID COVERAGE

The following services must be provided to ABP recipients, even though these services MAY NOT BE covered for standard Medicaid eligible recipients, but may already be required to be provided through an MCO to a member.
### 4. NOTES ON THE COVERAGE OF PREVENTIVE CARE SERVICES FOR ABP RECIPIENTS

- Preventive care services, typical of what is found in a commercial insurance plan, are covered for ABP recipients. Typically, this includes annual exams with all the components appropriate for the age, condition, and history of the recipient as recommended by various physician specialty associations and academies.
Additionally, for recipients who are aged 19 and 20, all of the screening and preventive services available to this age group under the EPSDT provisions are benefits for both ABP recipients and ABP Exempt recipients.

The requirements related to ABP include assuring the ABP population’s preventive care benefits include the recommendations of the United States Preventive Services Task Force (USPSTF). These recommendations are found at the following website:

http://www.uspreventiveservicestaskforce.org/recommendations.htm

ABP covered preventive services is not intended to be to only those services on the list. Other preventive services that are generally found in a commercial insurance plan would be covered. Also, the list is not intended to describe or replace the preventive screening and services available to EPSDT recipients.

Therefore, the following list includes items that may need special attention or comment, but we have removed items from the list that routinely performed in hospitals at the time of birth (PKU screening for example), and services for children for which the EPSDT screenings and service components are already more comprehensive. When the website above is updated, with new recommendations, those additions and charges are considered to be part of the requirement.

<table>
<thead>
<tr>
<th>Service</th>
<th>USPSTF Recommendations</th>
<th>Application to Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm</td>
<td>The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have never smoked.</td>
<td>Technically a new, requirement, but Medicaid would not currently deny a claim for this service.</td>
</tr>
<tr>
<td>Aneurysm screening: men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol misuse: screening and</td>
<td>The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams.</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
<td>The counseling component does not have to include any providers not currently covered by</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Anemia screening: pregnant women</td>
<td>The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease: men</td>
<td>The USPSTF recommends the use of aspirin for men ages 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Aspirin to prevent cardiovascular disease: women</td>
<td>The USPSTF recommends the use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Bacteriuria screening: pregnant women</td>
<td>The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Blood pressure screening in adults</td>
<td>The USPSTF recommends screening for high blood pressure in adults age 18 years and older.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>BRCA screening, counseling about</td>
<td>The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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<tr>
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</tr>
<tr>
<td>Breast cancer preventive medication</td>
<td>The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Breastfeeding counseling</td>
<td>The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.</td>
<td>At this time, based on comparison with commercial plans MAD interprets this as instruction or counseling that would occur during the routine prenatal care and postpartum care; and possibly assessed for any issues or lack of success by the pediatrician treating the newborn.</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Chlamydial infection</td>
<td>The USPSTF recommends screening for</td>
<td>Covered – already</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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<tr>
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</tr>
<tr>
<td>screening: nonpregnant women</td>
<td>Chlamydial infection in all sexually active nonpregnant young women age 24 years and younger and for older nonpregnant women who are at increased risk.</td>
<td>in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Chlamydial infection screening: pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men 35 and older</td>
<td>The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men younger than 35</td>
<td>The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women 45 and older</td>
<td>The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women younger than 45</td>
<td>The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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<tr>
<td>Colorectal cancer screening</td>
<td>The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>Covered – already in MC coverage requirements. The “depression care supports” component does not have to include any provider types not currently covered by the Medicaid program.</td>
</tr>
<tr>
<td>Diabetes screening</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Falls prevention in older adults: exercise or physical therapy</td>
<td>The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>At this time, based on comparison with commercial plans MAD interprets this as detection of the issue during routine annual preventive care exams, and referring as necessary. The referrals might be to community programs, home use of TV and DVD programs, etc. We do not believe the</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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</tr>
<tr>
<td>Falls prevention in older adults: vitamin D</td>
<td>The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Folic acid supplementation</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Gonorrhea screening: women</td>
<td>The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Healthy diet counseling</td>
<td>The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
<td>Coverage of this benefit exceeds the coverage currently found in Medicaid rules. It may include covering additional providers when there is a referral. May be performed by a physician, dietician, or other qualifying practitioner</td>
</tr>
<tr>
<td>Hepatitis B screening: pregnant women</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant</td>
<td>Technically a new, requirement, but</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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</tr>
<tr>
<td>women at their first prenatal visit.</td>
<td>good practitioners would already be performing this function during exams for high risk individuals.</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C virus infection screening: adults</td>
<td>The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.</td>
</tr>
<tr>
<td>HIV screening: nonpregnant adolescents and adults</td>
<td>The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.</td>
</tr>
<tr>
<td>HIV screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.</td>
</tr>
<tr>
<td>Intimate partner violence screening: women of childbearing age</td>
<td>The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams.</td>
</tr>
<tr>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent Covered – already in MC coverage requirements.</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Behavioral interventions.</td>
<td></td>
<td>May be performed by a physician, dietician, or other qualifying practitioner.</td>
</tr>
<tr>
<td>Osteoporosis screening: women</td>
<td>The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Rh incompatibility screening: first pregnancy visit</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Rh incompatibility screening: 24–28 weeks’ gestation</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks’ gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Sexually transmitted infections counseling</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Skin cancer behavioral counseling</td>
<td>The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.</td>
<td>Broader requirement than currently exists as a standard Medicaid recipient service.</td>
</tr>
<tr>
<td>Tobacco use</td>
<td>The USPSTF recommends that clinicians ask</td>
<td>Broader</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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<tr>
<td>----------------------------------------------</td>
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<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>counseling and interventions: nonpregnant adults</td>
<td>all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>requirement than currently exists as a standard Medicaid recipient service.</td>
</tr>
<tr>
<td>Tobacco use counseling: pregnant women</td>
<td>The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient service</td>
</tr>
<tr>
<td>Syphilis screening: nonpregnant persons</td>
<td>The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient service</td>
</tr>
<tr>
<td>Syphilis screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient service</td>
</tr>
</tbody>
</table>
L. APPENDIX L: ALTERNATIVE BENEFIT PLAN-EXEMPT MEDICALLY FRAIL CONDITIONS LIST
Alternative Benefit Plan-Exempt
Medically Frail Conditions List

Effective January 1, 2014

In order for a Category of Eligibility (COE) 100 (Other Adult Group) Medicaid member to be exempt from the Alternative Benefit Plan (ABP), he/she must have a documented medical diagnosis of one of the conditions or services listed below.

<table>
<thead>
<tr>
<th>1) Acquired Immune Deficiency Syndrome (AIDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS (Lou Gehrig’s Disease)</td>
</tr>
<tr>
<td>Angina Pectoris</td>
</tr>
<tr>
<td>Arteriosclerosis Obliterans</td>
</tr>
<tr>
<td>Artificial Heart Valve</td>
</tr>
<tr>
<td>Ascites</td>
</tr>
<tr>
<td>Assistance with one or more Activities of Daily Living (ADLs) – refer to the Nursing Facility Level of Care (NF LOC) Supplement effective January 1, 2014 (or subsequent replacement version)</td>
</tr>
<tr>
<td>Cancer (current diagnosis/treatment, within five years)</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>Chronic Substance Use Disorder – refer to the Chronic Substance Dependency (CSD) Criteria Checklist effective July 1, 2010 (or subsequent replacement version)</td>
</tr>
<tr>
<td>Cirrhosis of the Liver</td>
</tr>
<tr>
<td>Compromised Immune System</td>
</tr>
<tr>
<td>Coronary Insufficiency</td>
</tr>
<tr>
<td>Coronary Occlusion</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Dermatomayositis</td>
</tr>
<tr>
<td>Diabetes (Insulin Dependent)</td>
</tr>
<tr>
<td>Friedreich’s Disease</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemophilia</td>
</tr>
<tr>
<td>Hepatitis C (Active)</td>
</tr>
<tr>
<td>HIV+</td>
</tr>
<tr>
<td>Hodgkin’s Disease</td>
</tr>
<tr>
<td>Huntington’s Chorea</td>
</tr>
<tr>
<td>Hydrocephalus</td>
</tr>
<tr>
<td>Intermittent Claudication</td>
</tr>
<tr>
<td>Juvenile Diabetes</td>
</tr>
<tr>
<td>Kidney Failure</td>
</tr>
<tr>
<td>Lead Poisoning with Cerebral Involvement</td>
</tr>
<tr>
<td>Leukemia</td>
</tr>
<tr>
<td>Lupus Erythematosus Disseminate</td>
</tr>
<tr>
<td>Malignant Tumor (If treated/occurred within previous five years)</td>
</tr>
<tr>
<td>Metastatic Cancer</td>
</tr>
<tr>
<td>Motor or Sensory Aphasia</td>
</tr>
<tr>
<td>Multiple or Disseminated Sclerosis</td>
</tr>
<tr>
<td>Muscular Atrophy or Dystrophy</td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
</tr>
<tr>
<td>Myotonia</td>
</tr>
<tr>
<td>Open Heart Surgery</td>
</tr>
<tr>
<td>Organ Transplant</td>
</tr>
<tr>
<td>Paraplegia or Quadriplegia</td>
</tr>
<tr>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Peripheral Arteriosclerosis (If treated within previous three years)</td>
</tr>
<tr>
<td>Polyarteritis (Periarteritis Nodosa)</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>Polycystic Kidney</td>
</tr>
<tr>
<td>Posterolateral Sclerosis</td>
</tr>
<tr>
<td>Renal Failure</td>
</tr>
<tr>
<td>Serious Mental Illness – refer to the Serious Mental Illness (SMI) Criteria Checklist effective July 27, 2010 (or subsequent replacement version)</td>
</tr>
<tr>
<td>Sickle Cell Anemia</td>
</tr>
<tr>
<td>Silicosis</td>
</tr>
<tr>
<td>Splenic Anemia (True Banti’s Syndrome)</td>
</tr>
<tr>
<td>Still’s Disease</td>
</tr>
<tr>
<td>Stroke (CVA)</td>
</tr>
<tr>
<td>Syringomyelia</td>
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<tr>
<td>Tabes Dorsalis (Locomotor Ataxia)</td>
</tr>
<tr>
<td>Thalessemia (Cooley’s or Mediterranean Anemia)</td>
</tr>
<tr>
<td>Topectomy and Lobotomy</td>
</tr>
<tr>
<td>Wilson’s Disease</td>
</tr>
</tbody>
</table>
M. APPENDIX M: CHRONIC SUBSTANCE DEPENDENCY CHECKLIST
CSD determination is based on the age of the individual, diagnoses, functional impairment, and duration of the disorder and the diagnoses. Adults must meet all of the following criteria:

1. **Age:** Must be an adult 18 years of age or older.

2. **Diagnoses:** Have one of the following diagnoses that has been determined within the prior 12 months by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) specified from the list below:
   - Alcohol Dependence (303.90)
   - Cannibis Dependence (304.30)
   - Cocaine Dependence (304.20)
   - Amphetamine Dependence (304.40)
   - Hallucinogen Dependence (304.50)
   - Opioid Dependence (304.00)
   - Phencyclidine Dependence (304.60)
   - Sedative, Hypnotic, or Anxiolytic Dependence (304.10)
   - Polysubstance Dependence (304.80)

3. **Functional Impairment:** Have a Global Assessment of Functioning of 50 or below identified on Axis V that has been assessed within the prior 12 months by a licensed psychologist, LISW, LMFT, or LPCC under the classification system in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).

4. **Functional Domain:** Have a functional limitation on Axis IV that has been assessed within the prior 12 months by a licensed psychologist, LISW, LMFT, or LPCC under the classification system in the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).

5. **Duration:** Expected duration of the disorder is to be six months or longer.
N. APPENDIX N: SMI CHECKLIST
SMI determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnoses. Although some Axis II and other disorders are excluded as primary diagnoses, all Axis II or other disorders should be documented and are likely to affect engagement and treatment planning. Adults must meet all of the following five criteria:

1. **Age**: Must be an adult 18 years of age or older.
2. **Diagnoses**: Have one of the following diagnoses that has been determined within the prior 12 months by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) specified from the list below. ALL diagnoses require a GAF of 50 or below to qualify as SMI except for Schizophrenia subtypes.

### Schizophrenia and Other Psychotic Disorders
- Schizophrenia 295.30, 295.10, 295.20, 295.90, 295.60 (Does not require GAF)
- Schizophreniform Disorder 295.40
- Schizoaffective Disorder 295.70
- Delusional Disorder 297.1
- Brief Psychotic Disorder 298.8
- Shared Psychotic Disorder 297.3
- Psychotic Disorder NOS 298.9

*Psychotic Disorder NOS is included as it indicates the presence of significant and severe symptoms but precise diagnosis may not occur until further evaluation and treatment commences.*

### Major Depressive Disorders
- Major Depressive Disorder 296.xx

### Bi-Polar and Other Mood Disorders
- Bi-Polar Disorders 296.xx (all except Bi-Polar NOS 296.80)
- Cyclothymic Disorder 301.13
3. **Functional Impairment**: Have a Global Assessment of Functioning of 50 or below identified on Axis V that has been assessed within the prior 12 months by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR)

   — or —

   Have a diagnosis of Diagnosis of Schizophrenia (all 295.XX codes) that does not require a GAF determination.

4. **Functional Domain**: Have a functional limitation identified on Axis IV that has been assessed within the prior 12 months by a licensed psychiatrist, licensed psychologist, LISW, LMFT, or LPCC under the classification system in the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR).

5. **Duration**: Expected duration of the disorder is to be six months or longer.
O. Appendix O: NF LOC Supplement
DATE: October 25, 2013

TO: ALL MEDICAL PROVIDERS AND NURSING FACILITIES PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

FROM: JULIE B. WEINBERG, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: RACHEL WRIGHT, BUREAU CHIEF, QUALITY BUREAU

BY: ELIZABETH CASSEL, STAFF MANAGER, QUALITY BUREAU

SUBJECT: NEW NURSING FACILITY LEVEL OF CARE (NF LOC) CRITERIA AND INSTRUCTIONS TO REPLACE LONG TERM CARE UTILIZATION REVIEW FOR NURSING FACILITIES (8.312.2UR) EFFECTIVE JANUARY 1, 2014

Effective January 1st, 2014, the LONG TERM CARE UTILIZATION REVIEW FOR NURSING FACILITIES (8.312.2UR) will be replaced with new NF LOC Criteria and Instructions. This supplement describes the criteria that must be utilized for all NF LOC medical eligibility determinations after December 31, 2013. This Supplement also describes criteria for the determination of High and Low NF LOC ratings.

The new NF LOC Level of Care Criteria and Instructions can be found online at:
http://www.hsd.state.nm.us/mad/registers/2013.html
Effective Date: 01/01/2014

I. NEW NURSING FACILITY LEVEL OF CARE (NF LOC) CRITERIA AND INSTRUCTIONS

Background

The purpose of the Nursing Facility (NF) Level of Care (LOC) criteria and instructions is to define utilization review requirements for New Mexico Medicaid programs requiring a NF LOC. These criteria and instructions create a uniform, objective evaluation that can be applied consistently and equitably across the New Mexico Medicaid program. The criteria and instructions will be used by Human Services Department (HSD) or its designee to randomly audit the NF LOC ratings assigned to recipients. The documentation in the recipient’s medical record must support the rating.

To recognize that the clinical severity and resource utilization of recipients who require Nursing Facility (NF) placement spans a considerable spectrum, New Mexico Medicaid has established two payment categories of NF LOC. These categories are termed “High NF” and “Low NF.” They are constructs for payment methodologies to Nursing Facilities (NFs) and do not constitute different types of facilities. A rating of at least a “Low NF” LOC, also referred to as NF LOC, is required to receive New Mexico Medicaid home and community services such as the Program of All-Inclusive Care (PACE) and home and community based waiver services. All NFs are required to be able to provide adequate services across the spectrum of severity/intensity encompassed by High NF and Low NF.

For NF care, PACE, or other home and community based waiver services to be covered by Medicaid, a recipient must be financially eligible and medically eligible. To be medically eligible, a recipient must meet the criteria for at least a Low NF LOC. Recipients who require skilled services on a time limited basis due to temporary self-limiting decline from a baseline functional level would not meet medical eligibility requirements for NF coverage. If a recipient requires a level of care of higher intensity/resources that can be provided at a NF (example: acute care, acute rehabilitation), the recipient would not meet medical eligibility requirements for NF coverage. A recipient certified at the Low NF rate may need and receive some degree of skilled level of care services. The mere provision of skilled level of care services to a Medicaid recipient does not per se constitute qualification for the High NF payment level.

For Nursing Facilities, NF decisions are based solely on criteria supported by documentation in the medical record including physician notes, history and physical, physician orders, nursing notes, medication administration record, care plan, interdisciplinary progress notes, and therapy logs. The most recent Minimum Data Set (MDS) and Preadmission Screening and Resident Review (PASRR) determination or waiver shall be included as required for the initial NF stay. Uniform criteria and
instructions are used to establish whether a recipient's clinical condition meets criteria for Low NF or High NF eligibility.

When clinical information for the prior 30 days indicates the recipient meets criteria for a given level, the nurse reviewer may certify medical eligibility. If the documentation does not substantiate whether the recipient's condition meets criteria for the level being sought, the reviewer is obligated to refer the case to physician review. The medical record documentation shall support initial and ongoing eligibility.

A. Contractor Training

The Medicaid Managed Care Organizations (MCOs) and Third Party Assessor (TPA) will attend the initial training held by HSD. The MCOs and TPA will develop internal reviewer trainings, evaluation using HSD approved materials. Each MCO and TPA will submit an initial training material, evaluation and calendar of training events to HSD for approval. After final approval is given, HSD will attend the initial MCO and TPA internal trainings. The MCOs and TPA will ensure that all reviewers have, at a minimum, initial and annual training.

For new PACE eligible members transferring from an MCO, an existing NF LOC determination and functional assessment performed by the MCO can be used for NF LOC for PACE certification. For potential PACE members not in Medicaid Managed Care, the NF LOC determination would be performed by the TPA.

B. Requirements for Reviewer Qualifications and Quality Assurance

1. Reviewer Qualifications

   a. Meet the minimum criteria for education and experience.
      1) Active Nursing license in New Mexico or compact license (RN or LPN) with a minimum of 1 year of relevant experience.
      2) Medical Social Worker with a minimum of 1 year of relevant experience.
      3) Physical, Occupational, or Rehab Therapists with a minimum of 1 year of relevant experience.

   * All denials must be reviewed by a Physician (Medical Doctor or Doctor of Osteopathy) who must be licensed in the State of New Mexico and in good standing. All High NF determinations are to be reviewed by a nurse.

   b. Meet all training requirements. All Managed Care Organizations and the TPA will develop an internal training for the reviewers. Each reviewer must be trained, and have proof of completing the required training on file with the MCO (or TPA) before conducting a determination or redetermination.
The MCO shall provide HSD or its designee copies of training verification upon request. The training shall be valid for a maximum of one year at which time retraining will be required. The training shall be given to all reviewers before they to conduct a NF LOC evaluation or redetermination, and an annual training to recertify all trainers.

1) Initial training satisfactorily completed prior to using NF LOC tool.
2) Annual training.

2. Reviewer Quality

a. It is the reviewer's responsibility to be objective and use current documentation (in accordance with HSD policies) from the recipient's medical record to assure an accurate NF rating.

b. Each MCO or TPA will conduct internal quarterly random sample audits based on HSD NF LOC instructions and tool guidelines. The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HSD along with any Quality Performance Improvement Plan.

c. HSD or its designee will perform random external audits of each MCO and the TPA based on HSD NF LOC instructions and tool guidelines. The audit will include at a minimum accuracy, timeliness, training documentation of reviewers and consistency of reviewers. The findings will be reported back to the MCO and TPA on a quarterly and as needed basis. A Quality Performance Improvement Plan may be requested from the MCOs and TPA as a follow up to the findings.

C. Centennial Care Nursing Facility Determination Requirements

1. Determination for NF LOC is to be completed "within five (5) Business Days of the CONTRACTOR becoming aware the Member's functional or medical status has changed in a way that may affect a level of care determination. (Centennial Care contract- 4.4.10.1.11) Determination will be completed by the recipient's MCO by a trained reviewer using the HSD tool and instructions. This is for initial assessment and any time a recipient's functional or medical status has changed and may now qualify for a different level of care rating.

2. Community Benefit and PACE Settings - For Members meeting a nursing facility level of care, conduct a level of care reassessment at least annually (Centennial Care contract- 4.4.10.1.11).

3. Nursing Facility Setting- Initial Low NF determinations are valid for 90 days. Then a redetermination is required. The low NF redetermination is valid for 365 days. Initial High NF rating or change of status from Low NF to High NF rating will be valid for 30 days. A redetermination will be required after the
initial determination and is valid for 90 days. Redetermination is required every 90 days for High NF using the prior 30 days of medical record documentation and services received.

D. Medical Eligibility Instructions for Over Age 21

General Eligibility Requirement

Minimum Requirements for Low NF Determination: The recipient’s functional level is such that (2) two or more Activities of Daily Living (ADLs) cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate and/or assistance. The functional limitation must be secondary to a condition for which general treatment plan oversight of a physician is medically necessary. Determination is based on detailed documentation in interdisciplinary progress notes and care plans.

Minimum Requirements for High NF Determination: The recipient’s functional level must first meet the general eligibility requirement for Low NF. In addition, the recipient meets a minimum of 2 High NF requirements in 2 separate categories. (The exception to this is rehabilitative therapy. Therapies in excess of 300 minutes per week shall be considered as meeting the 2 HNF requirements in 2 separate categories, thus meeting HNF criteria). Determination is based on detailed documentation in interdisciplinary progress notes and care plans.

Not appropriate for NF care: The recipient’s needs are too complex or inappropriate for NF, such that:

- The recipient requires acute level of care for adequate diagnosis, monitoring, and treatment or requires inpatient based acute rehabilitation services.
- The recipient is completing the terminal portion of an acute stay and the skilled services are only being used to complete the acute therapy.
- Recipients who do not meet NFLOC criteria.
- The recipient requires services on an intermittent basis and has a functional level which does not require daily services at the skilled, professional or assistance level in order to accomplish ADLs.
- Recipient requires homemaker services to accomplish one or more ADLs, but is functional in accomplishing ADLs 4 or more days of the week.

E. Factors for Low NF

ADLs: To determine whether cognitive or physical impairment limits the recipient’s ability to complete the task independently. A determination that the recipient is limited to perform an ADL must be documented in the medical record together with ongoing daily/weekly notes indicating required care was provided.

Not consistent with NF: Independent with task, may require a longer period of time to complete, but is capable of safely completing task without help or is independent with
use of assistive devices such as wheelchair, walker or cane. Stress or other forms of intermittent incontinence which can be managed and cleansed by the recipient with minimal or occasional assistance. The recipient has an indwelling catheter other than a urinary catheter which is planned to be short-term and managed by home-health care. The recipient is able to independently care for catheter related needs between home health visits. The recipient is able to manage daily, routine indwelling urinary catheter care with no assistance.

**Dressing.** Once clothes are accessible and fasteners appropriately modified:
- Putting on and fastening clothes
- Putting on shoes

**Bathing/ Grooming.** Including the ability to:
- Get in and out of the shower or tub safely
- Turn on and off water/ regulate temperature
- Use soap or shampoo
- Wash and dry oneself
- Washing face
- Shaving face
- Brushing teeth
- Combing hair

**Eating.** Ability to bring food and fluid to mouth, chew and swallow.

**Meal acquisition/preparation.** Once food items appropriate to the recipient are in an appropriate, accessible location in residence, the ability to access and prepare the food in an edible state that over time meets age-appropriate nutritional needs. Includes preparation of cold foods re-heating of pre-made meals. Does not include meal planning diet teaching, shopping or issues of financial access. Does not include food choice or preference decisions of the recipient; the issue in question is capacity.

**Transfer.** Ability to move to and from bed and chair.

**Mobility.** Ability to move self from place to place by ambulation, wheelchair or other mechanically assisted means.

**Toileting.** Ability to:
- Properly sit on commode
- Adjust clothing properly
- Use commode
- Flush or empty commode
- Clean perineal area

**Bowel/ Bladder:** Continence of urine and stool or ability to self-manage if incontinent or there is abnormal bladder function.
Daily Medication: Administration - Inability to take necessary medications, defined as “life preserving” prescription medication, is a risk factor for Nursing Home Admission and will be considered as counting as 1 “ADL” in determining NFLOC.

To be judged as a risk factor, the inability to take medications must have documentation of:

1 - the occurrence of adverse outcomes from not taking medicines regularly. Adverse outcomes are hospitalizations, ER visits or evidence of decompensation; OR

2 - the necessary medications are clearly needed on a daily basis and there would be a high probability of decompensation or short term (within 14 days) adverse outcome without it (e.g. insulin for diabetes, anticonvulsants, Coumadin for clots). Examples of medications not meeting this criteria would be cholesterol lowering medication, thyroid replacement, or medications for acid reflux.

AND

3 - the inability to take necessary medications are caused by cognitive or behavioral problems (SMI or SED) which could be rectified with daily interventions.

*Volitional refusal to take medications or refusal to take necessary medication not caused by cognitive or behavioral problems (SMI or SED) and not rectifiable by daily intervention would not be considered a risk factor for NFLOC determination.

F. Factors for High NF

1. OXYGEN

High NF has one or more of the following:

a. Recipient is demonstrating unstable and changing oxygen needs which require specific direct skilled monitoring and/or intervention on a daily basis that is documented in interdisciplinary progress notes and care plans to maintain adequate oxygenation and to assess for respiratory depression. Evidence of a re-established baseline would be no evidence of significant change in oxygen therapy over 30 days.

b. It is medically necessary for the recipient to receive respiratory therapy at least once per day such that in the absence of such therapy there is a significant risk of pulmonary compromise due to known and predictable complications of a physician-diagnosed condition. The necessary therapy cannot be self-administered by the resident. This factor includes tracheostomy suctioning.
c. The recipient is ventilator dependent, but otherwise medically stable per documentation provided and the facility provides chronic ventilator management capability.

**Not consistent with NF.** Recipient requires supplemental oxygen which can be self-administered. The oxygen needs are stable. The recipient does not require daily skilled observation. Recipient requires intermittent respiratory therapy that may be administered by family or self-administered in a non-institutional setting. The recipient is ventilator dependent and has medical needs which cannot safely be met at a nursing facility.

2. **ORIENTATION/ BEHAVIOR:** identify the presence of certain behaviors that may reflect the level of an individual's emotional functioning and need for intervention. Behaviors should be assessed based on the documentation of interventions within the past 30 days for High NF. Documentation should include frequency, type of behavior, and if there has been or will be a request for Behavioral Health Services. Behaviors to include:

   a. **Wandering**- tendency to go beyond physical parameters of the environment in a manner that may pose a safety concern to self or others.

   b. **Self injury**- repeated behaviors such as biting, scratching, hitting, putting objects into mouth, ears, etc.

   c. **Harm to others**- throwing objects, physically attacking others or threatening behavior, etc.

   d. Other repeated behaviors that interfere with activities such as inappropriately removing clothing, sexual behavior, urinating or defecating in inappropriate places.

**High NF**

1. Demonstrates behavior on an ongoing and regular basis which threatens patient or other residents' safety and requires daily direct clinical skilled interventions which are documented in interdisciplinary progress notes and care plan.

2. Requires detailed care plan that documents a coordinated and consistent approach that occurs on a daily basis to either prevent or terminate behavior as documented in interdisciplinary progress notes and care plan.

**Not consistent with NF**

1. Does not have a cognitive impairment, but is trying to leave.
2. Paces due to anxiety, nervousness or boredom.
3. Wanders but does not require intervention.
4. Uses profanity to express anger.
3. Medication Administration

This excludes routine changes in medication doses, changes in medications, or stable doses of medications including but not limited to:

- Analgesics
- Antidepressants
- Anticonvulsants (given other than parenteral)
- Sliding scale insulin
- Thyroid medications
- Warfarin

High NF:

1. Initiation (first 30 days) or adjustment of medications (7 days after adjustment) in the following categories:
   - Anti-asthmatics/COPD: only during a respiratory exacerbation
   - Anti-infectives: only when given IV
   - Anti-hypertensives: only for med adjustments for systolic BP \( \leq 90 \) or \( > 160/120 \)
   - Anticonvulsants: only when given parenteral
   - Analgesics: only when given parenteral
   - Antiarrhythmics
   - Anti-diabetic agents: only following hypoglycemic reactions requiring glucagon or IV dextrose
   - Antipsychotics – daily monitoring by skilled staff for potential adverse reactions and sedation and daily documentation of changes in problematic behavior.

AND

2. Where at least every shift direct skilled monitoring of vital signs (respiratory rate, pulse, O2 saturation, blood pressure, temperature) and objective signs of pain or other distress, are necessary to ensure appropriate therapeutic effect of the medication as well as to detect signs of complications due to the medication that is documented in interdisciplinary progress notes and care plan.

Not Consistent with NF: Can administer own oral medications if given assistance in scheduling and assisted dispensing units. Can administer own subcutaneous insulin in pre-filled syringes; can administer own subcutaneous or intramuscular medications; and recipient is cognitively capable of reporting any adverse reactions to medications.

3. Rehabilitative Therapy

Rehabilitative therapy is provided by licensed respiratory therapist (RT), licensed physical therapist (PT), licensed occupational therapist (OT), and licensed speech language pathologist (SLP or “speech therapist”) under the direction of a
licensed practitioner (MD, NP, PA, or DO) and in accordance with a plan of treatment that is individualized and medically necessary.

**High NF:** It is medically necessary that the recipient receive one or more of the following documented therapies on a weekly basis: speech, physical, and/or occupational therapy. Therapy must be directed toward significant treatable functional limitations which affect ADLs. Therapy must be individualized, goal oriented, and in accordance with specific treatment plan goals in order to maximize recovery. Goals, expectation for improvement, and duration of therapy are medically reasonable and are documented in interdisciplinary progress notes and care plan. Therapy minutes should be documented on the Therapy Administration Record.

a. In the aggregate, such therapy must occur no less than 150 minutes per week.
b. Therapies at least 300 minutes per week shall be considered as meeting the 2 HNF requirements in 2 separate categories thus meeting HNF criteria.

**Not consistent with NF:** The recipient requires maintenance speech, physical, and/or occupational therapy achievable on an outpatient basis. Transportation needs are not considered, or the recipient requires maintenance speech, physical, and/or occupational therapy which can be performed independently or with home-based assistance.

4. **Skilled Nursing**

For purposes of New Mexico Medicaid, the term “skilled” services may carry a different meaning than used in other programs, such as Medicare. Medicaid skilled services are direct “hands-on” which can only be provided by a licensed professional acting within a defined scope of practice and in accordance with professional standards. Skilled services are those provided directly by registered nurses (RN), licensed practical nurse (LPN) under the direction of a licensed practitioner (MD, NP, PA, or DO) and in accordance with a plan of treatment that is individualized and medically necessary. A recipient with a healing wound that requires a simple dressing (does not require direct skilled intervention) or a healed wound will no longer be considered High NF. Examples of direct skilled nursing interventions include but are not limited to:

- Ostomy care
- Wound care/ dressings (pressure ulcers, stasis ulcers, injuries etc).
- Tube feedings
- IV therapy- Recipient is receiving daily IV medication, (two or more times daily), or continuous IV fluids.
- Parenteral nutrition or medications

**High NF:** Has one or more of the following...
1. Recipient has a new ostomy (first 30 days), and there is documentation in the interdisciplinary progress notes and care plan that the recipient requires active teaching, and requires direct skilled nurse monitoring and intervention of the ostomy site.

2. Wound Care
   a. Recipient has one or more documented stage III or IV decubitus ulcers requiring direct skilled nursing intervention and daily monitoring that is documented in interdisciplinary progress notes and care plan which includes location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection.
   OR
   b. Recipient requires documented skilled nursing intervention for two or more stage II decubitus ulcers at separate anatomic sites. Interventions are documented in the interdisciplinary progress notes and care plan no less than every 7 days, which include location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection.
   OR
   c. Recipient requires documented daily or more frequent sterile dressing changes (and/or irrigation) for significant, unstable lesions that require frequent nursing observation such as poorly healing, or infected wounds. Recipient must be unable to accomplish wound care. Interventions are documented in the interdisciplinary progress notes and care plan no less than every 7 days, which include location, class/stage, size, base tissues, exudates, odor, edge/perimeter, pain and an evaluation for infection.

Not consistent with NF: Recipient receives services outside of the NF that are billed separately, i.e., dialysis, therapies, transfusions, at a wound care clinic, etc or indwelling foley catheter/suprapubic tube or drain.

5. Other Clinical Factors
High NF:
The recipient is comatose, in a persistent vegetative state, or is otherwise totally bed bound and totally dependent for all ADLs related to a documented medical condition requiring direct skilled intervention (not monitoring) by a licensed nurse or licensed therapist to prevent or treat specific, identifiable medical conditions which pose a risk to health. The recipient’s ability to communicate needs, report symptoms, and participate in care is severely limited and is documented in interdisciplinary progress notes and care plan.
FEEDING
High NF has one or more of the following documented in interdisciplinary progress notes and care plan:

PARENTERAL
It is documented that the recipient receives medically necessary parenteral nutrition (PN) solutions via non-permanent or permanent central venous catheter (Hickman, Groshong, Broviac, etc.), via peripherally inserted central catheter (PICC), or via peripheral access sites.

ENTERAL
It is documented that the recipient receives some or all nutrition through a nasoenteric feeding tube (i.e., a tube placed through the nose) AND it is documented that one or more of the permissive conditions for nasoenteric feeding at the Low NF level are not met which include all of the following: the tube feeding is uncomplicated, the resident is alert with an intact gag reflex, and the resident is able to be fed either upright in a chair or with a bed raised to at least 30 degrees and preferably 45 degrees. The recipient receives enteral nutrition via gastrostomy, jejunostomy, or other permanent tube feeding methods.

6. Mobility/Transfer
High NF: The recipient is bed bound, unable to independendty transfer and has a clinical condition(s) such that the transfer itself is not routine, is reasonably viewed as posing unusual risks, and there is documentation in interdisciplinary progress notes and care plan that demonstrate that each transfer must be and is monitored by a licensed nurse to assure no clinical complications of the transfer have occurred.

G. Instructions for Community Benefit Eligibility
The assessment for Community Benefit ADLs may be done in the home by a Care Coordinator. The reviewer for the contractor will determine eligibility and eligible services for Community Benefits by applying the level of care criteria based on the Care Coordinators assessment of the ADLs. To be eligible for Community Benefits and services, the recipient must meet the Low NF Criteria. The Comprehensive Needs Assessment (CNA) will be used for low NF evaluation. Eligibility for Community Benefit does not guarantee receipt of services or service hours. Service hours are generated by the MCO or HSD contractor and depend on further assessment based on the CNA, considering both community and natural supports (See PCS regulations 8.315.4.1). In the event that a recipient is not safe to stay in the community setting, the recipient’s care coordinator or designee shall coordinate the transition to the appropriate care setting.
Minimum Requirements for Community Benefit Eligibility: The recipient's functional level is such that (2) two or more Activities of Daily Living cannot be accomplished without consistent, ongoing, daily provision, or some or all of the following levels of service: skilled, intermediate and/or assistance. The functional limitation must be secondary to a condition for which general treatment plan oversight of a physician is medically necessary. Determination is based on detailed documentation in interdisciplinary progress notes and care plans.

H. Instructions for PACE/ non-Centennial care Eligibility
The reviewer will determine eligibility and eligible services for PACE/ Non-Centennial Care by applying the level of care criteria. To be eligible for PACE/ Non-Centennial Care and services, the recipient must meet the Low NF Criteria. The MAD 379 abstract together with the history and physical will be used for evaluation.

Minimum Requirements for PACE/ Non-Centennial Care eligibility: The recipient's functional level is such that (2) two or more ADLs cannot be accomplished without consistent, ongoing, daily provision, or some or all of the following levels of service: skilled, intermediate and/or assistance. The functional limitation must be secondary to a condition for which general treatment plan oversight of a physician is medically necessary. Determination is based on detailed documentation in interdisciplinary progress notes and care plans.

I. Instructions for Eligibility for Members Age 21 and Under
The use of age and function appropriate milestones and guidelines are used for all persons age 3 years through 20 years of age. For ages 0-35 months the child's provider may make a referral and send an assessment based on age appropriate ADLs.

Since this population's ability to perform ADLs may be expected to change as members age, the Member's ability to perform ADLs will be based on the Member's requirement for assistance for the next twelve months. If there are potential improvements are expected in six months, the assessment may be redone in a six month timeframe.
Appendix A - DEFINITIONS

Skilled: For purposes of New Mexico Medicaid, the term “skilled” services may carry a different meaning than used in other programs, such as Medicare. Medicaid skilled services are direct “hands-on” which can only be provided by a licensed professional acting within a defined scope of practice and in accordance with professional standards. Skilled services are those provided by registered nurses (RN), licensed practical nurse (LPN), licensed respiratory therapist (RT), licensed physical therapist (PT), licensed occupational therapist (OT), and licensed speech language pathologist (SLP or “speech therapist”). Skilled services are highly individualized and directed toward the evaluation, monitoring, treatment, or amelioration of specific clinical conditions. Skilled services are provided under the direction of a licensed practitioner (MD, NP or DO) and in accordance with a plan of treatment that is individualized and medically necessary.

Intermediate: Intermediate services are direct “hands-on” services which can only be provided by certified (or similarly officially qualified) personnel who have received specialized training and are supervised by licensed professionals. Such services are directed toward specific needs of a resident as a result of a specific clinical condition. Examples include services provided by certified nurse assistants (CNA) and physical therapy aids.

Assistance: Assistance services are direct and/or indirect services including cueing and prompting which are general in nature, principally independent of specific medical needs, which do not require extensive training in performance, and do not require oversight by supervising professionals. Examples include food set-up and assistance with cutting food, bathing and grooming assistance, shopping assistance, money management, and routine transfer assistance. Assistance services may be provided by persons capable of providing professional or skilled services, but if the services do not require persons with that level of expertise, they remain assistance level services.

Daily: For skilled, intermediate, and assistance services, at least once a day. For therapies, at least five times per week.

ADLs: Activities of Daily Living
- Dressing. Once clothes are accessible and fasteners appropriately modified, putting on and fastening clothes; putting on shoes.
- Grooming. Once in front of appropriately modified sink, turning on water, washing face, shaving face, brushing teeth, and combing hair.
• Bathing. Once in an appropriately modified bath of shower, ability to turn on water and wash head and body.
• Eating. Once in front of food, ability to bring food and fluid to mouth, chew and swallow.
• Meal acquisition/preparation. Once food items appropriate to the recipient are in an appropriate, accessible location in residence, the ability to access and prepare the food in an edible state that over time meets age-appropriate nutritional needs. Includes preparation of cold foods re-heating of pre-made meals. Does not include meal planning diet teaching, shopping or issues of financial access. Does not include food choice or preference decisions of the recipient; the issue in question is capacity.
• Transfer. Ability to move to and from bed and chair.
• Mobility. Ability to move self from place to place by ambulation, wheelchair or other mechanically assisted means.
• Toileting. Ability to properly sit on commode, adjust clothing properly, use commode, slu... or empty commode, and clean perineal area.
• Bowel/bladder control and management. Continence of urine and stool or ability to self-manage if incontinent or abnormal bladder function.

**IADLs:**

**Instrumental Activities of Daily Living**
• Answering telephone. Includes use of special modifying equipment.
• Making a telephone call
• Shopping (once in store, selecting groceries and other items of necessity)
• Transportation ability. The manner by which transports self from place of residence to other places beyond walking distance.
• Prepare meals. Ability to prepare meals as desired, beyond simple meal acquisition/preparation; does not include meal planning.
• Laundry. Ability to put clothes in washer or dryer, starting and stopping machine, removing clothes, and drying clothes.
• Housekeeping. Dusting, vacuuming, sweeping, and routine cleaning of kitchen and bathroom.
• Heavy chores. Moving furniture, yard work, windows, and manually cleaning oven.
• Taking non-essential medication. Assuming use of assistive dispensing devices as needed, the ability to recognize and properly self-administer medications which are used for comfort or amelioration of symptoms, but which do not preserve life or avert serious morbidity.
• Handling money. Ability to properly pay, count change, pay bills, and balance checkbook.
**Unstable:** A clinical condition which requires daily skilled reassessment in order to prevent serious morbidity. Such reassessment must lead to clinical decision-making and a reasonable potential must exist that treatment goals may be modified and/or immediate skilled interventions might occur based on the results of the monitoring. The definition is broader than used in acute settings. An unstable condition does not necessarily mean that immediate death might result from lack of monitoring; only that serious morbidity might result. An unstable condition may be chronic and have no prognosis for improvement. Evolving processes for which monitoring is necessary in order to determine the seriousness of the process are also unstable conditions for the purposes of these criteria.

**Medically Necessary:**

Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

- Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual
- Are provided within professionally accepted standards of practice and national guidelines
- Are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider, or the payor.

Application of the definition:

- A determination that a health care service is medically necessary does not mean that the health care services is a covered benefit or an amendment, modification, or expansion of a covered benefit
- The utilization review contactor is making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
  1. Evaluating individual physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training as appropriate
2. Considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views, and
3. Considering the services being provided concurrently by other services delivery systems

- Physical, mental and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.
## Appendix B- Required Documentation by Benefit

### Initial and Annual (Continued Stay [CS]) NF Determination

<table>
<thead>
<tr>
<th></th>
<th>Nursing Facility</th>
<th>Community Benefit</th>
<th>PACE</th>
</tr>
</thead>
<tbody>
<tr>
<td>*PASRR (I, II, or waiver)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDS-most recent</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**MAD 379</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medical Documentation- H &amp; P+ physician order dated within 6 months for initial and 12 months for annual (CS)</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Comprehensive Needs Assessment</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*only for initial request

**MCO request for approval form
<table>
<thead>
<tr>
<th>BATHING</th>
<th>GROOMING</th>
<th>DRESSING</th>
<th>EATING</th>
<th>TOILETING</th>
<th>MOBILITY</th>
<th>TRANSERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
</tr>
<tr>
<td>Able to bathe self with supervision</td>
<td>Able to brush teeth and hair and wash hands</td>
<td>Chooses clothes; able to dress self. May</td>
<td>Able to feed self by using fork or spoon; begins</td>
<td>to use toilet independently; may need assistance</td>
<td>Walks and runs, Hops and skips. Able to walk;</td>
<td>Able to move from bed to chair or chair to</td>
</tr>
<tr>
<td></td>
<td>and face. May need help with &quot;styling&quot; hair.</td>
<td>need help with zippers or buttons.</td>
<td>to use knife.</td>
<td>with wiping.</td>
<td>may use cane, crutches, or walker.</td>
<td>chair without assistance.</td>
</tr>
<tr>
<td>☐ Requires physical help or adaptive</td>
<td>☐ Requires physical help by caretaker to</td>
<td>☐ Requires physical assistance with</td>
<td>☐ Requires one-to-one monitoring to prevent choking</td>
<td>☐ Incontinent during the day and has medical</td>
<td>☐ Does not walk, even with assistive device.</td>
<td>☐ Uses mechanical lift or has to be physically</td>
</tr>
<tr>
<td>equipment to support head or trunk; or is</td>
<td>complete tasks; or is combative with grooming</td>
<td>getting clothes on and off; is unable to</td>
<td>or aspiration; or needs to be fed; or is tube-fed</td>
<td>diagnosis to support incontinence; or must be</td>
<td>Wheelchair or bed bound; requires standby</td>
<td>lifted or moved from bed to chair or chair to</td>
</tr>
<tr>
<td>combative and requires 2 people to</td>
<td>tasks.</td>
<td>assist with getting arms in sleeves or legs</td>
<td>or receives TPN.</td>
<td>be physically placed on and off toilet.</td>
<td>assistance to prevent falling.</td>
<td>chair.</td>
</tr>
<tr>
<td>complete task.</td>
<td></td>
<td>in pant legs; or is combative with tasks.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Functional impairment expected to last for</td>
<td>☐ Functional impairment expected to last for</td>
<td>☐ Functional impairment expected to last for</td>
<td>☐ Functional impairment expected to last for</td>
<td>☐ Functional impairment expected to last for</td>
<td>☐ Functional impairment expected to last for</td>
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<tr>
<td>at least 6 months from date of assessment</td>
<td>at least 6 months from date of assessment</td>
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<td>at least 6 months from date of assessment</td>
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<td>at least 6 months from date of assessment</td>
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<tr>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
</tr>
</tbody>
</table>

NOTES______________________________________________________________

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______________________________________________________________
<table>
<thead>
<tr>
<th>ADL'S AGE 6-9 years</th>
<th>Member Name_________________________</th>
<th>dob________</th>
<th>Member number________</th>
</tr>
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<tbody>
<tr>
<td><strong>BATHING</strong></td>
<td><strong>GROOMING</strong></td>
<td><strong>DRESSING</strong></td>
<td><strong>EATING</strong></td>
</tr>
<tr>
<td>Developmental</td>
<td>Developmental</td>
<td>Developmental</td>
<td>Developmental</td>
</tr>
<tr>
<td>Able to bathe</td>
<td>Able to brush teeth, wash hands and</td>
<td>Able to dress</td>
<td>Able to feed self</td>
</tr>
<tr>
<td>self with minimal</td>
<td>and face, and brush hair (with</td>
<td>self, with</td>
<td>(minimal assistance</td>
</tr>
<tr>
<td>prompting or</td>
<td>exception of securing or styling</td>
<td>exception of</td>
<td>required for use of</td>
</tr>
<tr>
<td>oversight.</td>
<td>long hair).</td>
<td>zippers and</td>
<td>utensils).</td>
</tr>
<tr>
<td>□ Requires</td>
<td>□ Requires step-by-step</td>
<td>□ Requires</td>
<td>□ Requires one-to-one</td>
</tr>
<tr>
<td>adaptive</td>
<td>oversight to complete task or</td>
<td>physical</td>
<td>monitoring to</td>
</tr>
<tr>
<td>equipment; needs</td>
<td>physical help.</td>
<td>assistance</td>
<td>prevent choking or</td>
</tr>
<tr>
<td>to be lifted into</td>
<td></td>
<td>by the care</td>
<td>aspiration; or needs</td>
</tr>
<tr>
<td>or out of tub or</td>
<td></td>
<td>giver to</td>
<td>to be fed or tube</td>
</tr>
<tr>
<td>shower. Is</td>
<td></td>
<td>get clothes</td>
<td>fed; requires TPN.</td>
</tr>
<tr>
<td>combative or</td>
<td></td>
<td>on and off</td>
<td>physical help on</td>
</tr>
<tr>
<td>requires 2</td>
<td></td>
<td>toilet.</td>
<td>and off toilet.</td>
</tr>
<tr>
<td>caregivers to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>complete task.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Functional</td>
<td>□ Functional</td>
<td>□ Functional</td>
<td>□ Functional</td>
</tr>
<tr>
<td>impairment expected</td>
<td>impairment expected to last</td>
<td>impairment</td>
<td>impairment expected</td>
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<td>to last for at least</td>
<td>for at least 6 months from date of</td>
<td>expected to</td>
<td>for at least 6</td>
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<td>6 months from</td>
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<td>last for at</td>
<td>months from date of</td>
</tr>
<tr>
<td>date of assessment</td>
<td></td>
<td>last for at</td>
<td>assessment</td>
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<td>last for at</td>
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<tr>
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<th><strong>DRESSING</strong></th>
<th><strong>EATING</strong></th>
<th><strong>TOILETING</strong></th>
<th><strong>MOBILITY</strong></th>
<th><strong>TRANSFERS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Milestones - Able to bathe or shower independently.</td>
<td>Developmental Milestones – Able to brush teeth, wash hands and face, and groom hair with minimal or no assistance.</td>
<td>Developmental Milestones – Able to dress self independently.</td>
<td>Developmental Milestones – Able to feed self without prompting or assistance.</td>
<td>Developmental Milestones - Independent with bowel and bladder toileting. Should be learning to self-catheterize.</td>
<td>Developmental Milestones - Able to walk; may use cane, crutches, or walker.</td>
<td>Developmental Milestones - Able to move from bed or chair without assistance.</td>
</tr>
<tr>
<td>□ Requires adaptive equipment or needs physical assistance getting in and out of tub or shower; Is combative or unsafe without caregiver oversight.</td>
<td>□ Requires physical assistance or constant cueing by caretaker to complete tasks; or is combative with grooming tasks.</td>
<td>□ Requires physical assistance by caretaker to get clothes on and off.</td>
<td>□ Requires one-to-one monitoring to prevent choking or aspiration; or needs to be fed; or is physically unable to assist with tube feedings or TPN prep.</td>
<td>□ Incontinent of bladder or bowel; requires verbal prompting or step-by-step cueing to complete tasks of toileting.</td>
<td>□ Does not walk, even with assistive device; wheelchair or bed bound; Requires standby assistance to prevent falling.</td>
<td>□ Uses mechanical lift or has to be physically lifted or moved from bed to chair or chair to chair.</td>
</tr>
<tr>
<td>□ Functional impairment expected to last for at least 6 months from date of assessment</td>
<td>□ Functional impairment expected to last for at least 6 months from date of assessment</td>
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<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
<td>Developmental Milestones-</td>
</tr>
<tr>
<td>Able to bathe or shower independently.</td>
<td>Able to brush teeth, wash hands and face, and</td>
<td>Able to dress self independently; begins to</td>
<td>Independent with bladder and bowel toileting.</td>
<td>Able to walk; May use cane, crutches, or</td>
<td>Able to walk; May use cane, crutches, or</td>
<td>Able to move from bed or chair with</td>
</tr>
<tr>
<td></td>
<td>groom hair with minimal assistance. Begins</td>
<td>care about current styles.</td>
<td></td>
<td>walker.</td>
<td>walker.</td>
<td>without assistance.</td>
</tr>
<tr>
<td></td>
<td>to care about appearance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Requires adaptive equipment, or needs</td>
<td>□ Requires physical assistance or constant</td>
<td>□ Requires physical assistance by caregiver</td>
<td>□ Incontinent of bladder or bowel; or</td>
<td>□ Does not walk, even with assistive device;</td>
<td>□ Uses a mechanical lift or has to be</td>
<td></td>
</tr>
<tr>
<td>physical assistance getting in and out of</td>
<td>cueing by caretaker to complete tasks; or is</td>
<td>to get clothes on and off.</td>
<td>requires verbal prompting or step-by-step</td>
<td>Is Wheelchair or bed bound; or needs stand-by</td>
<td>physically lifted or moved from bed to chair</td>
<td></td>
</tr>
<tr>
<td>tub or shower; Is combative or unsafe without</td>
<td>combative with grooming tasks.</td>
<td></td>
<td>cueing to complete tasks of toileting.</td>
<td>assistance to prevent falling.</td>
<td>or chair to chair.</td>
<td></td>
</tr>
<tr>
<td>caregiver oversight.</td>
<td></td>
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<tr>
<td>□ Functional impairment expected to last for</td>
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</tr>
<tr>
<td>at least 6 months from date of assessment</td>
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<td>at least 6 months from date of assessment</td>
<td>at least 6 months from date of assessment</td>
<td></td>
</tr>
<tr>
<td>□ Re-evaluate in 6 months</td>
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<td>□ Re-evaluate in 6 months</td>
<td>□ Re-evaluate in 6 months</td>
<td>□ Re-evaluate in 6 months</td>
<td>□ Re-evaluate in 6 months</td>
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**NOTES**
<table>
<thead>
<tr>
<th>ADL'S 14-18 years</th>
<th>Member Name _______________________________ dob __________ Member number ______</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BATHING</strong></td>
<td><strong>GROOMING</strong></td>
</tr>
<tr>
<td>Developmental Milestones-Able to bathe or shower independently; chooses when to bath.</td>
<td>Developmental Milestones-Independent with grooming; cares about grooming.</td>
</tr>
<tr>
<td>☐ Requires adaptive equipment or needs physical assistance getting into and out of tub or shower; or is combative or unsafe without caregiver oversight.</td>
<td>☐ Requires physical assistance or constant cueing to by caretaker complete tasks; or is combative with grooming tasks.</td>
</tr>
<tr>
<td>☐ Functional impairment expected to last for at least 6 months from date of assessment</td>
<td>☐ Functional impairment expected to last for at least 6 months from date of assessment</td>
</tr>
<tr>
<td>☐ Re-evaluate in 6 months</td>
<td>☐ Re-evaluate in 6 months</td>
</tr>
</tbody>
</table>

**NOTES**
<table>
<thead>
<tr>
<th>BATHING</th>
<th>GROOMING</th>
<th>DRESSING</th>
<th>EATING</th>
<th>TOILETING</th>
<th>MOBILITY</th>
<th>TRANSFERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developmental Milestones- Able to shower or bathe independently; Frequently showers or baths.</td>
<td>Developmental Milestones- Independent with grooming; Cares about grooming.</td>
<td>Developmental Milestones- Able to dress self independently.</td>
<td>Developmental Milestones- Able to feed self; Capable of minor food prep.</td>
<td>Developmental Milestones- Independent with bowel and bladder toileting.</td>
<td>Developmental Milestones- Able to walk; may use a cane, crutches, or walker.</td>
<td>Developmental Milestones- Able to move from bed or chair without assistance.</td>
</tr>
</tbody>
</table>

- [ ] Requires adaptive equipment, or needs physical assistance getting into and out of bath or shower; or needs step-by-step cues to complete task; or is combative or unsafe without caregiver oversight.

- [ ] Requires physical assistance or constant cueing to complete tasks; or is combative with grooming tasks.

- [ ] Requires one-to-one monitoring to prevent choking or aspiration; or needs to be fed; or is physically unable to assist with tube feedings or TPN prep.

- [ ] Incontinent of bowel or bladder; or requires step-by-step cueing to complete tasks of toileting.

- [ ] Does not walk, even with assistive device. Wheelchair or bed bound; Or requires standby assistance to prevent falling.

- [ ] Requires a mechanical lift or has to be physically lifted or moved from bad to chair or chair to chair.

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Functional impairment expected to last for at least 6 months from date of assessment

- [ ] Re-evaluate in 6 months

- [ ] Re-evaluate in 6 months

- [ ] Re-evaluate in 6 months

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- [ ] Re-evaluate in 6 months

- [ ] Re-evaluate in 6 months