# New Mexico Human Services Department

Medical Assistance Division Managed Care Policy Manual

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1 GENERAL PROVISIONS

Revision dates: August 15, 2014; March 3, 2015

Effective date: January 1, 2014

GENERAL INFORMATION

The purpose for the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by the New Mexico Human Services Division (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 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 New Mexico Administrative Code (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.

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 LODs 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 Managed Care Agreement and NMAC 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 NMAC 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 505-827-3100.
2 PROVIDER NETWORK

Revision dates: August 15, 2014, March 1, 2017
Effective date: January 1, 2014

PROVIDER TERMINATIONS and SERVICE ELIMINATION

Anticipated changes in the MCO provider network shall be reported to the MAD and BHSD Contract Managers 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 of the MCO’s knowledge about the change.

The MCO is required to submit a Notification, Narrative and Transition Plans A, and Transition Plan B as appropriate, to its Contract Manager on anticipated changes to the network. Refer to the appendices included in this section for HSD templates. The Manager for either the Behavioral Health (BH) Unit or the Long-Term Support Services (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 fifteen (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.

**MCO INITIATED PROVIDER NETWORK CLOSURES AND REDUCTIONS**

1. The MCOs will submit a written request to HSD regarding a significant change in the MCO’s provider network to include either closure or reduction of providers. A significant change is defined as:
   - A. Affecting more than 100 members statewide or;
   - B. Affecting more than 100 members in urban area; and/or
   - C. Affecting more than 50 members in rural area; and/or
   - D. Affecting more than 25 members in frontier area.
   - E. Limits or removes member choice of providers, e.g., closure of BH network, in rural and frontier areas
2. The request must be submitted at least sixty (60) calendar days prior to the MCO’s intended action.
3. The request must include a completed Transition Notification and justification for the closure or reduction of the specific provider network.
4. The MCO must submit a current Geo/Access report demonstrating member access and include the accessibility overview, map and analysis of provider network.
5. HSD will review and provide the MCO with a written approval or denial within 10 working days.
6. At HSD’s discretion, the MCOs may be required to submit all transition plan documents.

**PROVIDER MONITORING**

HSD/MAD monitors access and provider networks in a variety of ways and through various reports. The following methods are utilized to monitor MCO provider access and network adequacy:
   - A. Provider Satisfaction Survey
   - B. Member Satisfaction Survey
C. Secret Shopper Survey
D. Consumer Assessment of Healthcare Providers and Systems (CAHPS) results
E. External Quality Review Organization (EQRO) Reviews
F. MCO Call Center Reports
G. Grievance & Appeals Reports
H. PCP Report
I. Geo Access Report
J. Network Adequacy Report
K. Ad Hoc Reports
2.A

NOTIFICATION OF CHANGE IN SERVICES ☐
NOTIFICATION OF TRANSITION ☐

*Expected Change ☐ *Unexpected Change ☐

Date:

Date MCO Notified of Closure:

Anticipated Date of Closure:

Name of Provider or Facility:

<table>
<thead>
<tr>
<th>Type of Provider</th>
<th>Individual: ☐</th>
<th>Group: ☐</th>
<th>Agency ☐</th>
<th>Facility: ☐</th>
</tr>
</thead>
</table>

Full contract termination? Yes ☐ No ☐

Addresses of all locations (include county and region type):

<table>
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<tr>
<th>Type(s) of Service(s):</th>
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</table>

Satellite location terminating? Yes ☐ No ☐

Address of location terming (include county and region type):

<table>
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<tr>
<th>Type(s) of Service(s) at location:</th>
</tr>
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Terminating Services only? Yes ☐ No ☐

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<tr>
<th>Type(s) of Service(s):</th>
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Total Number of Members Affected: <21 ☐ >21 ☐

Transition Plans Required? Yes ☐ No ☐

Narrative Due Date:
(Due 10 calendar days after Notification)

The below items should be filled in only if transition plans are required.

Narrative, Transition Plans A & B Due Date:
(Due 15 calendar days after Notification)

Name of MCO Staff and/or Care Coordinator Responsible for Transition:

* Notification of unexpected change is due within five (5) business days of confirmed change. Notification of expected change is due thirty (30) days prior to the confirmed change.

CC 2014, Revised: 02/2017
2.B

Narrative

For

(Provider/Facility Name)

MCO Staff and/or Care Coordinator:

Date:

Describe the reason(s)/circumstance(s) and any contributing factors to the change or closure:

How the change affects delivery of, or access to, covered services (describe how the change impacts the system as whole and at the community level):

The MCO’s plan for maintaining access and the quality of Member care:
Please explain all factors considered in making the determination that the change will not significantly impact the system and provide assurances that all Members will be transitioned to new providers (if applicable).

Transition issues identified
## 2.C

### TRANSITION PLAN A

**Overall Transition Plan Information**

**MCO Transition Plan**

For

**(Provider Name)**

**(Date)**

<table>
<thead>
<tr>
<th>MCO task assignment</th>
<th>Comments</th>
<th>Begin Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>1. Preplanning</td>
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<tr>
<td>A. MCO receives communication of contract, location or service closure.</td>
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<td>B. Closing program sends a formal letter to MCO advising of closing</td>
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<tr>
<td>C. List of affected members sent to MCO</td>
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<tr>
<td>D. List of special problems expected or associated with transition</td>
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<tr>
<td>E. MCO letter to affected members offering assistance (as needed)</td>
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A. Contracting Department to complete TABLE A Provider Information.

### 3. Transition planning

A. Meeting with program or Director

B. Complete plan to ensure the program is appropriately referring and transitioning affected Members.

C. Progress updates of transition program

D. Template for Records Retention Completed and attached

### 3. Communication to HSD

A. Submit Notification

B. Submit narrative

C. Submit Transition Plan A

D. Submit Transition Plan B

E. Bi-weekly updates of transition plans and narrative from MCO to state agency contact person

### 4. Care Coordination

A. Identify care coordinators to be contact point for members seeking assistance

B. Care Coordinator review of community resources
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<tr>
<td>C. Coordinate care coordination and MCO Clinical/UM Department tasks</td>
<td></td>
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<td>D. Compile weekly report of care coordination</td>
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<td>E. Meeting with MCO and program transition team to coordinate efforts, if applicable</td>
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<td>5. Other requirements as needed depending on circumstances of closing</td>
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<td>6. Transition Plan Finalized</td>
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MCO certifies that the transition of all members has taken place and is finalized.

Signature: ____________________________
Date: ____________________________
## TRANSITION PLAN B

**Member Specific Information**

<table>
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<tr>
<th>Member Name</th>
<th>Social Security Number</th>
<th>Medicaid ID</th>
<th>Member Date of Birth</th>
<th>Guardian (if applicable)</th>
<th>Services currently receiving (therapy, med monitoring, PICO)</th>
<th>Current Provider, address, phone number, county</th>
<th>County in which member receives services</th>
<th>Service County Status: Rural, Urban or N/A</th>
<th>Data of discharge</th>
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## TRANSITION PLAN B

**Member Specific Information**

*Provider Name*

*Date*

<table>
<thead>
<tr>
<th>New Provider</th>
<th>Date of Transition or Anticipated Date</th>
<th>Appointment Date (for Outpatient Services)</th>
<th>Care Coordinator and Phone Number (If Applicable)</th>
<th>Special Conditions/Arrangements (Housing Issues, Social Issues, etc.)</th>
<th>Special Condition/Arrangement Behavioral Health Code(s) - See Special Conditions Legend</th>
<th>MOO Notified? (Y, N, NA)</th>
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*Revised 02/2017*
3 MEMBER EDUCATION

Revision dates: August 15, 2014; March 1, 2016, September 1, 2016
Effective date: January 1, 2014

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 NMAC.

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

The information is provided electronically after obtaining the enrollee’s consent to receive the information electronically.

A. The format is readily accessible;
B. The information is placed in a location on the MCO’s Web site that is prominent and readily accessible;
C. The information is provided in an electronic form which can be electronically retained and printed;
D. The information is consistent with the content and language requirements of Section 438.10; and
E. The enrollee is informed that the information is available in paper form without charge upon request and the MCO provides it upon request within 5 business days.

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

MEMBER EDUCATION PRIOR APPROVAL PROCESS

The MCO shall submit all written materials that will be distributed to Members (referred to as Member Materials) to HSD’s Communication and Education Bureau’s Marketing Coordinator and copy its HSD Contract Manager. 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 mailed to members unless the member requests the material in an alternative format.

All Member Materials must be submitted to HSD in electronic file media, in the format prescribed by HSD and in accordance with Paragraph E of Section 11 of the Manual. The MCO 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 MCO’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) business days from the date of submission. The “15 day” timeframe for approval or denial shall only apply to the specific date of the initial submission. Modifications of any type would need to be resubmitted, which may delay approval.

Prior to modifying any approved Member Material(s), the MCO shall submit to HSD for prior written approval a detailed description of the proposed modifications in accordance with this section of the Manual.

**MEMBER HANDBOOK**

The MCO member handbook must include the following:

1. MCO demographic information, including the organization’s hotline telephone number and hours of operation.
2. 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.
3. Member bill of rights and member responsibilities, including any restrictions on the member’s freedom of choice among network providers.
4. 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).
5. How to obtain care in emergency and urgent conditions and that prior authorization is not required for emergency services.
6. The amount, duration and scope of mandatory benefits.
7. 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.
8. Limitations to the receipt of care from out-of-network providers.
9. A list of services for which prior authorization or a referral is required and the method of obtaining both.
10. Information on Utilization Management (UM) Services.
11. A policy on referrals for specialty care and other benefits not furnished by the member’s PCP.
12. Information on how to obtain pharmacy services.
13. Notice to members about the grievance process and about HSD’s fair hearing process.
14. Information on the member’s right to terminate enrollment and the process for voluntarily dis-enrolling from the plan.
15. Information on the MCO switch process.
16. Information on how members change their demographic information.
17. Information regarding advance directives including advance directives for behavioral health.
18. Information regarding how to obtain a second opinion.
19. Information on cost sharing, if any.
20. 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.
21. Value added benefits which are not covered by the contract and how the member may access those benefits.
22. Information regarding the birthing option program.
23. 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.
25. Information on member’s privacy rights.

**PROVIDER DIRECTORIES**

The MCO may choose to maintain regionalized provider directories by Northern, Southern and Central regions of the State; however, each regionalized provider directory must include telephone numbers for crisis lines, Member Services line, all out of state providers and Bernalillo County providers. Information on how to access these regionalized provider directories online or request a copy should be indicated on the MCO’s website and in the Member Handbook.

**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:

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

**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.
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. Contract directly with a consumer-run business. The MCOs will retain financial responsibility for this function.

1. 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.
2. 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 copy will be retained by the consumer run business and HSD. 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.
3. 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:

1. How the surveyor should conduct themselves during the phone interview.
2. 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.

1. Conduct an evaluation of the consumer/family surveyor training and the implementation of the instrument within 10 business days of the training being conducted.
2. Send Letters of Introduction to the facilities where the face-to-face survey is to be conducted.
3. 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.
4. Review survey data results and identify interventions and metrics for system improvement(s) with the C/F/YSP State Steering Committee.
5. Report on performance improvement project(s) related to survey findings to HSD as requested.
6. 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.
2. Write and publish the annual Consumer Satisfaction Project Report.
3. Populate five Uniform Reporting System (URS) tables with the results of the C/FYSP as per SAMHSA.
**4  CARE COORDINATION**

Revision dates: August 15, 2014; February 23, 2015; March 3, 2015; March 1, 2016, September 1, 2016, March 1, 2017

Effective date: January 1, 2014

**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.

**CARE COORDINATION FUNCTIONS**

The following primary care coordination functions are requirements for care coordination that must be performed by staff employed by the MCO:

1. Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and are not currently identified for Care Coordination Level 2 or 3 services;
2. Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
3. Administering the Centennial Care Community Benefit Service Questionnaire (CBSQ) as applicable (see CBSQ Section);
4. Semi-annual or quarterly in-person visits with the member;
5. Quarterly or monthly telephone contact with the member; and
6. Comprehensive Care Plan (CCP) development and updates.

Other care coordination activities that will enhance the Care Coordination program may be subcontracted to “extenders,” such as community health workers; furthermore, MCOs may delegate one or more of the four primary care coordination functions above in the following instances:

1. MCOs that own and operate patient-centered medical homes (PCMHs) as part of their provider network may delegate to such PCMHs as early as January 1, 2014, provided the PCMH care coordinator is employed by the MCO.
2. MCOs may delegate all primary Care Coordination functions to a designated Section 2703 Health Home after April 1, 2016, provided the health home is determined ready by the Health Home Steering Committee to perform such functions.
3. MCOs may submit proposals to HSD for other potential delegation functions of care coordination.

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:

   a. level of care assessments and reassessments occur on schedule in compliance with the contract and are submitted to the lead or supervising care coordinator;
   b. comprehensive needs assessments and reassessments, as applicable, occur on schedule in compliance with the contract;
   c. care plans are developed and updated on schedule in compliance with the contract;
   d. care plans reflect needs identified in the CNA and reassessment process;
   e. care plan goals are member-centric, and agreed-upon by the member;
   f. care plans are appropriate and adequate to address the member’s needs including the need for all Community Benefit services;
   g. services are delivered as described in the care plan and authorized by the MCO;
   h. services are appropriate to address the member’s needs:
   i. services are delivered;
   j. service utilization is appropriate;
   k. service gaps are identified and addressed;
   l. minimum care coordinator contacts are conducted;
   m. care coordinator-to-member ratios are appropriate; and
   n. 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.

C. The MCO, or its HSD approved designee, 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 care coordination level assignments 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. Include notes regarding how such a referral was handled by the care coordinator, including any additional follow up;
h. Establish a schedule of services for each Member identifying the time 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.

HEALTH RISK ASSESSMENT (HRA)

The MCO shall conduct the Human Services Department (HSD) standardized Health Risk Assessment (HRA) on all members who are newly enrolled in Centennial Care for the purpose of (i) introducing the MCO to the Member, (ii) obtaining basic health and demographic information about the Member, and (iii) confirming the need for a CNA.

The standardized HRA will be completed for each new Centennial Care Member within thirty (30) Calendar Days of the Member’s enrollment in the MCO. Additionally, a HRA will be completed upon a change in the Member’s health condition if the member is not currently identified for Care Coordination Level 2 or Level 3 services. The HRA may be conducted by telephone, in-person, or as otherwise approved by HSD; HRA information must be obtained from the Member or representative and must be documented in the Member’s file. The MCO shall ensure its staff, subcontractors or vendor(s) conducting the HRA, are adequately trained to effectively conduct the HSD standardized HRA.

The MCO will make reasonable efforts to contact Members to conduct a HRA and provide information about care coordination. Such efforts shall include, but shall not be limited to, engaging community supports such as Community Health Workers, Core Service Agencies (CSAs) and Centers for Independent Living. The MCO shall document at least three (3) attempts to contact a Member which includes at least one (1) attempt to contact the Member at the phone number most recently reported by the Member. The three (3) attempts shall be followed by a letter sent to the Member's most recently reported address that provides information about care coordination and how to obtain a HRA. Documentation of the three (3) attempts shall be included in the Member’s file. Such attempts shall occur on not less than three (3) different Calendar Days, at different hours of the day, including day and evening hours and after business hours.
The HSD standardized HRA includes the following information:

A. Member Demographics
   a. Member Name, address, telephone number, date of birth;
   b. Member Medicaid number;
   c. Names and relationship of person(s) completing form (other than member);
   d. Emergency contact and telephone number;
   e. HRA date; and
   f. Assessment Method and Type.

B. Member Health Information
   a. Language preference, translation needs, and special preferences (cultural, religious, physical);
   b. Main health concern;
   c. Current or past physical and Behavioral Health conditions or diagnoses, including brain injury;
   d. Pending physical or Behavioral Health procedures;
   e. Most recent physical examination and/or recent medical appointment;
   f. Emergency room visits, including reason, number of visits and dates of visit(s);
   g. Number of hospital stays in past 6 months, and any readmissions;
   h. Indication of a 1915 (c) waiver level of care assessment or client individual assessment;
   i. Number of Medications;
   j. Living situation;
   k. Assistance with two (2) or more activities of daily living and type of need;
   l. Interest in and need for Long-Term Care services;
   m. Advance directives preference and interest in receiving information; and
   n. Interest in receiving care coordination.

The MCO shall provide the following information to every member during his or her HRA:

1. Information about the services available through Care Coordination
2. Information about the Care Coordination Levels (CCLs)
3. Notification of the member’s right to request a higher Care Coordination Level
4. Requirement for an in-person CNA for the purpose of providing services associated with Care Coordination level 2 or level 3
5. Information about specific next steps for the member

Within seven (7) Calendar Days of completion of the HRA, all members shall be informed of the need for a CNA.

MCOs may request to add additional questions to the HRA to meet the requirements of regulatory and accrediting bodies by submitting the additional questions to be included and the reason(s) for inclusion for State approval. Requests must be sent for approval to the Human
Services Department, Medical Assistance Division through the MCO’s Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

For the purpose of the MCO completion of the HSD standardized HRA the following definitions apply:

Frequent emergency room use is defined as two (2) or more emergency room visits in a six (6) month period.

Poly-pharmaceutical use is defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class.

**COMPREHENSIVE NEEDS ASSESSMENT (CNA)**

A CNA is conducted for Medicaid members eligible for managed care who are identified through the HRA as having significant health conditions and risk indicators signifying the potential need for Level 2 or Level 3 Care Coordination. The MCO shall schedule a CNA within fourteen (14) Calendar Days of completion of the HRA and complete the CNA within thirty (30) Calendar Days of completion of the HRA unless the member is in a model approved for delegated care coordination functions with other State approved guidelines.

Members who are identified as not needing a comprehensive needs assessment shall be monitored by the care coordination unit quarterly through predictive modeling software and available utilization and claims data to identify a Member’s current and emergency needs related to a potential need for increased care coordination.

For members who reside in a nursing facility, rather than conduct a CNA, the MCO shall ensure the MDS is completed and collect supplemental information related to Behavioral Health needs and the Member's interest in receiving Community Benefit Services.

The CNA will assess the Member’s physical, behavioral health, and long-term care needs; identify potential risks and provide social and cultural information. The results of the CNA will be used to create the care plan which is based on the member’s assessed needs and may also include a functional assessment, if applicable.

The CNA is the sole responsibility of the MCO care coordinator unless delegated to a HSD approved designee.

CNAs must be performed through the utilization of an assessment tool that has been approved by HSD for 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 or HSD approved designee. The
comprehensive needs assessment must be conducted by a primary care coordinator, employed by the MCO or HSD approved designee. 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 or HSD approved designee.

The CNA must be conducted in the member’s primary place of residence or in the nursing home for those residents reintegrating back into the community. In scheduling the comprehensive needs assessment, the MCO or its HSD approved designee 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 CNA interview process.

CNAs must be conducted 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 where there is an identifiable address, and the member is residing for an established period of time for shelter, safety, physical assistance, recovery, legal requirements, or treatment services.

The CNA may be conducted without requesting an exception from the State under the following conditions:

1. If the member is homeless, or in a transition home and the assessment can be conducted in a private setting 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.
2. If the member is currently part of the jail involved population preparing for release.

Other requests for exceptions to the CNA requirements for assessments that cannot be completed face to face or in the member’s home setting must be made directly to HSD by the MCO using the following process:

1. Complete the Centennial Care CNA Exception Request form (MAD 601).
2. Alternate locations submitted to HSD for review, should be assessed for privacy to ensure that the member’s Protected Health Information (PHI) is not jeopardized.
3. Send the completed MAD 601 by secure E-mail to: HSD-QB-CCU-CNA@state.nm.us
4. HSD will review the request and respond to the specific MCO requestor within 2 business days.
5. If an exception is approved, it shall only be valid for the duration of 6 months, or until the next CNA is needed, whichever comes first.
6. Requests will not be reviewed or approved if submitted:
   a. Via unsecure email
b. To an email address other than HSD-QB-CCU-CNA@state.nm.us

c. Via any format other than the MAD 601 Form

All efforts must be made to negotiate with and educate the member about the importance of participating in the completion of 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 practice of conducting in home CNAs further allows for observation of the existence of other parties living in the home and possibly presenting support or risk to the member.

If a member establishes a new residence following completion of the CNA due to transition from a facility, temporary housing location or completion of a program or treatment, the Care Coordinator shall consider this a trigger event to determine if the member may need to be re-assessed through a CNA in the new setting. If an in home assessment may be in the member’s best interest, the Care Coordinator shall conduct a new assessment based on this triggering event. If the Care Coordinator determines a new CNA is not necessary based on this triggering event, the member record shall reflect the reason for determining that an additional CNA was not necessary.

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 to the member outlining a basic care plan with minimum services outlined and suspending any requests for increased services/personal care hours until a CAN and NFLOC is conducted and completed.

At a minimum, the CNA shall:

1. 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 screening questionnaire, as approved by HSD/BHSD 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 (ADL) (mobility, grooming, bathing, eating, dressing, medications (i.e. self- administration and safety) and Instrumental ADLs/IADLs (i.e. money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, grocery shopping).

2. Assess Long-Term Care needs including but not limited to: environmental safety including items such as smoke detectors, pests/infestation, and trip and fall dangers and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the Community Benefit, the MCO shall assess for all Community Benefit services.

3. Include a risk assessment, using a tool and protocol approved by HSD, 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.

4. Assess disease management needs, including identification of disease state, need for targeted intervention and education, and development of appropriate intervention strategies.

5. 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); Individualized Education Plan (IEP); and Individualized Service Plans for Developmental Disabilities, Medically Fragile, or Mi Via Waiver Program recipients, (if applicable).

6. 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.

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

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

9. In the event the Member is a minor under the age of eighteen (18), identify the parent or legal guardian participating and/or responding for the minor during assessment.

**COMMUNITY BENEFIT SERVICE QUESTIONNAIRE (CBSQ)**

As part of the CNA process, MCO care coordinators must administer the Community Benefit
Services Questionnaire (CBSQ). The CBSQ assists the care coordinator in discussing all available Community Benefit (CB) services with the member, and the Community Benefit Member Agreement (CBMA) elicits the member’s participation in identifying risks.

The completed CBSQ and the CBMA are considered part of the member’s CNA. The MCOs must ensure all care coordinators are trained in conducting this process. The MCOs will also submit a HSD approved monthly report to HSD that will include the total number of CBSQs completed and the number of member refusals to participate in the CBSQ.

The CBSQ/CBMA will be administered for the following members:

1. Allocated members receiving their first CNA, including members who are in the process of community reintegration.
2. All annual CNAs for members with a current NF LOC (see note about CCL3 members below).
3. Full Medicaid members without a NF LOC who request Community Benefit (CB) services.
4. Full Medicaid members without a NF LOC who have not requested CB service but appear to meet NF LOC criteria during the CNA.

The CBSQ/CBMA will not be administered for the following members:

1. Members who have not previously met NF LOC and are not requesting CB at the time of the CNA.
2. Members who may meet a NF LOC for a short period of time due to a clinical episode (ie, pregnancy).
3. Members not being assessed for a NF LOC.
4. Members on the DD, Mi Via or MF Waivers (COEs 095 and 096).
5. Members in a nursing facility (unless in the process of being allocated through community reintegration or member has a COE (i.e. SSI) that deems them eligible to reintegrate without a waiver allocation).
6. Members who decline assessment for NF LOC or refuse CB services. The MCO care coordinator must document the refusal in the member’s record.

Care coordination level 3 (CCL3) members:

1. For all members with CCL3 and a NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the care coordinator.
2. For members with CCL3 but without a NF LOC, follow the criteria above.

In any circumstances not covered by the criteria, the care coordinator should use his/her judgment and consult with his/her supervisor as necessary to determine appropriate use of the CBSQ.
Care Coordinators should use the CBSQ as a tool to guide the discussion with the member and/or the member’s representative to inform them of the availability of CB services.

**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 need for conducting a new CNA to be performed may include but are not limited to, significant changes in Member’s medical and/or behavioral health condition (decline or improvements in health status); 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. These events may at times not require a new CNA be completed. If a new CNA is not conducted, the member’s record should clearly establish why the triggering event did not result in the MCO conducting a new CNA. The decision can be made via telephone contact or face to face visit with the member.

**COMPREHENSIVE CARE PLAN (CCP) REQUIREMENTS**

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. The MCO or HSD approved designee is responsible for ensuring a CCP is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the CCP.

A. CCP Scope and Process. The MCO or HSD approved designee must establish a process to ensure coordination of care for members that includes:

1. Coordination of the member’s physical, behavioral and long-term health care needs through the development of the CCP;
2. Collaboration with the member, member’s friends and family (at member’s request), members PCP, specialists, Behavioral Health providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan, including documentation of all attempts to engage providers and other
individuals identified in the development of the care plan;
3. With the member’s 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 member’s physical health care issues when working with the member); and
4. Verification of all decisions made regarding the member’s needs and services, and ensures all information is documented in a written, comprehensive care plan.

B. CCP Development and Management
1. The Care Plan serves as a working and guiding tool of reference for integrating the member’s care plan(s) into a language that the member and/or family member can understand. The member shall lead the person-centered planning process to ensure the care plan is Member-centric and agreed-upon by the member.
2. The member may designate his/her representative to have a participatory role, as needed, and as defined by the member, unless the representative has decision making authority, under law. The MCO or HSD approved designee shall develop and authorize the CCP within fourteen (14) Business Day of completion of the comprehensive needs assessment unless the member is in a health home and/or using the Treat First model of care.
3. The Care Coordinator shall:
   a. Ensure the member or member’s legal representative understands, reviews, signs and dates the care plan.
   b. Provide a copy of the member’s completed care plan to the member, member’s 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).
   c. With the member’s consent, confirm that family, providers, or any other relevant parties are included in the treatment and planning of the member’s care plan.
   d. Ensure timelines for the development and implementation and/or update the CCP are met.
   e. Facilitate treatment and coordinate with providers to assist the member and his or her family with navigating the system including scheduling appointments, arranging transportation, or advocating for the member as needed.
   f. 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.
   g. With Member’s consent, maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the member's care.
   h. 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; including strategies for solving conflicts or disagreements, and provide clear conflict-of-interest guidelines for all planning participants.

i. Identify and list specific risk factors and changes to member’s risk, address those changes and update the member’s risk agreement and CCP as necessary to include measures to minimize the identified risks.

j. Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.

k. Educate members with identified disease management needs by providing specific disease management interventions and strategies.

l. 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.

m. Educate member about non Medicaid services available as appropriate (e.g. Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant Mental Health).

n. Reflect cultural considerations of the member and conduct the care plan process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

4. Required Elements of a CCP 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. Member’s current status, including present levels of function in physical, behavioral health 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, with member’s consent, including but not limited to: the care coordinator, social worker, registered nurse, medical
director, PCP and others as identified by member must be identified to develop, implement and update the care plan as needed.

j. Reflect that the setting in which the individual resides is chosen by the member, and is integrated in and supports full access of members receiving HCBS, to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

k. Reflect the member’s strengths and preferences.

l. Identify goals and desired outcomes, reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals, and include who will provide the services and supports.

m. Identify goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others.

t. Include those services, the purpose or control of which the member elects to self-direct.

o. Prevent the provision of unnecessary or inappropriate services and supports.

5. CCP Revisions

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

   i. Risk of significant harm-the care coordination team will convene within one business day of the MCO receiving notification, in person or by teleconference; if necessary the care plan will be modified accordingly within 72 hours;

   ii. Major medical change;

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

   iv. A serious accident, illness, injury or hospitalization that disrupts the implementation of the CCP;

   v. Serious or sudden change in behavior;

   vi. Change in living situation, including out-of-home placements and subsequent discharges;

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

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

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

   x. Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or
xi. As requested by HSD.

b. Within five (5) Business Days of completing a reassessment of a member’s needs, the care coordinator shall update the Member’s CCP as appropriate, and the MCO or HSD approved designee shall authorize and initiate services in the updated CCP.

6. Ongoing Care Coordination Description

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

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

   i. Identify gaps and address the needs of the member, including develop and/or update the care plan as needed.

   ii. Ensure when a member’s level of care coordination increases or decreases that continuity of care is always maintained.

   iii. Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.

   iv. Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member’s goals and foster independence.

   v. 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.

   vi. Education regarding service delivery through Medicare and/or Medicaid.

   vii. 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.

   viii. Achieve coordination of physical, behavioral health and long term care services.

   ix. Maintain consistent communication and contact with member’s PCP, specialists, and other individuals involved in the member’s care.

   x. Maintain and monitor the member’s Community Benefit and provide assistance with complex services.

   xi. Consider member and provider input to identify opportunities for improvement.

   xii. Collaborate and/or cooperate with representatives of the Independent Consumer Support System (ICSS).
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 HRA (HRA) activities, the MCO shall ensure its staff, subcontractor(s) or vendor(s) conducting the HRA, is adequately trained to effectively conduct the HSD standardized HRA. CNAs must be performed by primary care coordinators employed by the MCO other than when delegated as allowable. The MCO may use local resources, such as Indian Health Service, Tribes and Tribal Organizations and Urban Indian Organizations (I/T/Us); PCMH, Health Homes, CSAs for Behavioral Health; 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, promotora, 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 other than when delegated as allowable by the State. 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 as follows:

A. Care coordination level 2:
   a. Members not residing in a nursing facility 1:75, and
   b. Members residing in a nursing facility 1:125; and
   c. Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit 1:100;

B. Care coordination level 3:
   a. Members not residing in a nursing facility 1:50; and
   b. Members residing in a nursing facility 1:125; and
   c. Members age twenty-one (21) and over who participate in the Self-Directed Community Benefit in care coordination 1:75; and

C. Care coordination for Members who participate in the Self-Directed Community Benefit:
   a. Members under age of twenty-one (21) 1:40

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 or HSD approved designee shall submit, upon request by HSD, a 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 ratios;
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 or HSD approved designee, 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 the 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 or HSD approved designee, is unable to provide a Native American care coordinator to such Members when requested, the MCO or HSD approved designee 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 or HSD approved designee must accommodate the Member’s requests to change to a
different care coordinator if desired and if there is an alternative care coordinator available. Such availability may take into consideration the MCO’s or HSD approved designee’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 or HSD approved designee 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 or HSD approved designee may need to initiate change in a Member’s assigned care coordinator:

1. Assigned care coordinator is no longer employed by the MCO or by the HSD approved designee;
2. There is a conflict of interest preventing neutral support for the Member;
3. Care Coordinator is on temporary leave from employment; or
4. Caseload of the assigned care coordinator must be adjusted due to its size or intensity.

The MCO or HSD approved designee shall develop policies and procedures regarding notice to Members of care coordinator changes initiated by either the MCO or HSD approved designee, or Member, including notice of planned care coordinator changes initiated by the MCO or HSD approved designee.

The MCO or HSD approved designee shall ensure continuity of care when care coordinator changes are made. The MCO or HSD approved designee 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 and include documentation of such transition in the Member’s file.

Initial training shall be provided by the MCO or HSD approved designee 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.

**ENGAGEMENT OF MEMBERS**

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.

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.

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 clinical staff member 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:

1. Establish/discuss optimal outcome for health and safety.
2. Identify the issues interfering with optimal health and safety outcomes.
3. Clarify roles for each member of the team.
4. Clarify rules of engagement (who can call who when, etc.) and program regulations.
5. Assign tasks to each team member with timeline.
6. Sign agreement that documents the discussion and assignment of tasks and holds each member accountable.
7. 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.)
8. Schedule updates between participants, MCO staff on a regular basis.
9. Ensure 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
MCO COORDINATION WITH 1915 (c) HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS: DEVELOPMENTAL DISABILITIES, MEDICALLY FRAGILE, & MI VIA

The MCOs provide acute and ancillary medical and behavioral health services to the 1915 (c) HCBS recipients/MCO members. The MCO is responsible for ensuring a Comprehensive Care Plan is initiated upon enrollment and assigning a Care Coordinator for coordinating all services in the MCO Comprehensive Care Plan. The MCOs are required to perform all care coordination functions described in this policy manual section including but not limited to: capturing the member’s medical and behavioral health needs; developing a comprehensive care plan; and completing all required touch points identified by the member’s current CC level. Exceptions to care coordination functions are specifically described below for members receiving 1915 (c) HCBS waiver services.

OVERVIEW OF MEDICAID 1915 (c) HCBS WAIVER PROGRAM

A. Developmental Disabilities Waiver Program
The Developmental Disabilities Medicaid Waiver (DDW) provides an array of home and community based services to help individuals with developmental disabilities live successfully in their community, become more independent, and reach their personal goals. New Mexico has used waiver funding to support people with developmental disabilities for over 26 years. The DDW serves individuals who meet an Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Level of Care (LOC). DDW individuals have a COE 096.

The DDW provides the following long term home and community based services: behavioral support consultation, case management, community integrated employment services, customized community supports, customized in-home supports, crisis support, environmental modification, independent living transition service, intensive medical living supports, living supports, non-medical transportation, nutritional counseling, personal support technology, preliminary risk screening and consultation related to inappropriate sexual behavior, adult nursing, respite, socialization and sexuality education, supplemental dental care, and therapies. DDW services are supplementary to early periodic screening, diagnostic, and treatment (EPSDT) benefits for recipients under the age of 21.

DDW services and budget are outlined in the recipient's Individualized Service Plan (ISP). The ISPs are developed through a person-centered planning process which allows recipients to select services that will help them achieve personally defined outcomes in the most integrated community setting. The ISP is created by the DDW recipient with the assistance of their DDW case manager and the DDW Interdisciplinary team (IDT). The DDW case manager provides information, support, guidance, and assistance to
recipients during the Medicaid eligibility process and afterwards during the ISP development. The IDT serves to help the recipient identify supports, services and goods that meet their need for DDW services and are specific to the recipient’s qualifying condition.

B. Medically Fragile Waiver Program

The Medically Fragile Waiver (MFW) serves individuals who have been diagnosed with a medically fragile condition defined as a life threatening, chronic condition which results in a prolonged dependency on skilled nursing care at home. MFW individuals have a COE 095. MFW recipients meet an ICF/IID Level of Care (LOC) as well as established medically fragile parameters.

MFW provides the following long term care services: RN Case Management, private duty nursing (RN, LPN), home health aide, behavior support consultation, respite care, nutritional counseling, skilled therapies (PT, OT, SLP) for adults, and specialized medical equipment. MFW services are supplementary to early periodic screening, diagnostic, and treatment (EPSDT) benefits for recipients under the age of 21.

The UNM Health Sciences Center, Center for Development and Disability (UNM-CDD) has a Medically Fragile Case management Program (MFCMP) that currently provides RN/case management services to both MF waiver and non-waiver (EPSDT) medically fragile persons state wide. Case Managers from the UNM/MFCMP assess the recipient for medically fragile parameters, compile the LOC forms, and submit the LOC packet to the Medicaid Third Party Assessor for an ICF/IID LOC determination. Case Managers also create the MFW recipient’s Individualized Service Plan (ISP) that includes services and budget amounts determined by the LOC.

C. Mi Via Self-Directed Waiver Program

Mi Via is the State of New Mexico’s self-directed waiver program serving individuals who meet an ICF-IID LOC. Medicaid recipients served through the Mi Via waiver are referred to as “participants”. Mi Via participants have a Medicaid Category of Eligibility (COE) of either COE 095 Medically Fragile or COE 096 Developmentally Disabled and a Setting of Care (SOC) of “MIV”. The goal of Mi Via is to provide long-term home and community-based alternatives that facilitate greater participant choice and control over the types of services and supports they receive. It is important to distinguish that Mi Via is a self-directed waiver program that is operated separately from the Centennial Care Self-Directed Community Benefit Program.

Mi Via provides the following services: consultant/support guide services, behavior support consultation, community direct support, customized community supports, in-home living supports, emergency response network, employment supports services, environmental modification services, home health aide, homemaker/direct support
services, nutritional counseling, personal plan facilitation, private duty nursing for adults, respite, skilled therapies for adults, specialized therapies, related goods, and non-medical transportation. Mi Via services are supplementary to early and periodic screening, diagnostic, and treatment (EPSDT) benefits for participants under the age of 21 years old.

Mi Via waiver services and budget are outlined in the participant’s Service and Support Plan (SSP). The SSPs are developed through a person-centered planning process which allows participants to select services that will help them achieve personally defined outcomes in the most integrated community setting. The SSP is created by the Mi Via participant with the assistance of their Consultant. Consultants provide information, support, guidance, and assistance to participants during the Medicaid eligibility process and afterwards during SSP development. Consultants serve to help the participant identify supports, services and goods that meet their need for Mi Via waiver services and are specific to the participant’s qualifying condition. The level of support a Consultant provides is unique to the individual participant and their ability to self-direct in the Mi Via program.

MCO CARE COORDINATION ACTIVITIES & THE 1915 (c) HCBS WAIVER SERVICE PLAN (ISP OR SSP)

A. Developmental Disabilities Waiver Program

The MCO Care Coordinator shall:

1. Request a copy of the approved DDW LOC abstract (MAD 378 form) and client individual assessment (CIA) from the Medicaid Third Party Assessor (TPA) for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs.
   a. A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC abstract and CIA.
   b. The Care Coordinator has no influence in regards to the DDW services and budget. The Care Coordinator cannot make recommendations or changes to the DDW ISP and Budget.
2. The MCO will not complete a NF LOC on members enrolled in the DD 1915 (c) Waiver.
3. Utilize the DDW LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the recipient/member.
4. Have knowledge that while the MCO is responsible for annual CNA visits, the DD waiver case manager assists the member with the DD waiver LOC assessment process and ISP and Budget development. Utilize only the physical health and behavioral health portion of the MCOs’ Comprehensive Care Plan for members
who are receiving home and community based services through the DD waiver.

B. Medically Fragile Waiver Program

The MCO Care Coordinator shall:
1. Request a copy of the approved MFW LOC packet and ISP packet from the UNM/MFCMP prior to the completion of the CNA. The MCO will utilize the LOC and ISP information to complete as much of the CNA as possible prior to the visit.
2. Ensure that the MFW ISP serves as the Comprehensive Care Plan for the MF member.
3. Work with the UNM/MFCMP to coordinate MFW LOC assessments and/or CNA visits at the same time in order to reduce the burden on these families.
4. The MCO will not complete a NF LOC on members enrolled in the MF 1915 (c) Waiver.
5. Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The UNM/MFCMP will conduct monthly visits and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CNA as needed.
6. Conduct the required annual in person visit and CNA for MF members.
7. Utilize the MFW ISP as the Comprehensive Care Plan for the MFW recipient.

C. Mi Via Self-Directed Waiver Program

The MCO Care Coordinator shall:
1. Request a copy of the approved Mi Via LOC abstract (MAD 378 form) and client individual assessment (CIA) from the TPA for the purpose of obtaining a complete, comprehensive picture of the participant and their needs.
   a. A CIU/MAD 054 form is faxed to the Medicaid TPA to request the LOC abstract and CIA.
   b. The Care Coordinator has no influence in regards to the Mi Via goals, services, and budget. The Care Coordinator cannot make recommendations or changes to the Mi Via SSP and Budget.
2. The MCO will not complete a NF LOC on members enrolled in the Mi Via 1915 (c) Waiver.
3. Utilize the LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the participant/member.
4. Have knowledge that while the MCO is responsible for the annual CNA visits, the Consultant assists the participant with the annual Mi Via waiver LOC assessment process (which requires the TPA to conduct an in-home assessment of long-term HCBS needs). The MCO and Consultant are encouraged to coordinate the CNA
visits and LOC in-home assessment at the same time in order to reduce the burden to the participant/member and the participant’s family.

5. Utilize only the physical health and behavioral health portion of the MCOs’ Comprehensive Care Plan for members who are receiving home and community based services through the Mi Via waiver.

**MCO CARE COORDINATOR ACTIVITIES FOR MEDICALLY FRAGILE EPSDT (NON-WAIVER) MEMBERS CASE MANAGED BY UNM/MFCMP**

The MCOs are contracted with UNM/MFCMP to continue to provide RN/case management services for those individuals (non-waiver) who meet the medically fragile criteria. The same medically fragile parameters are utilized for non-waiver members.

For Medically Fragile (MF) EPSDT (non-waiver) clients, the MCO Care Coordinator shall:

1. Request a copy of the approved MF ISP from the UNM/MFCMP prior to the completion of the CNA. The MCO will utilize the information in the ISP to complete as much of the CNA as possible prior to the annual visit.
2. The MCO will not complete a NFLOC assessment on MF EPSDT members.
3. Ensure that the MF ISP serves as the Comprehensive Care Plan for the MF member.
4. Work with the UNM/MFCMP to coordinate MF LOC assessments, annual re-assessments, and the CNA in-person visits at the same time in order to reduce the burden on these MF members and families.
5. Not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF members. The UNM/MFCMP will conduct monthly visits or phone conference calls with the MCO care coordinator and provide the MCO with copies of the visit notes. The MCO will review the visit notes monthly and update the CCP as needed.
6. Conduct the required annual in person visit and CNA for MF members.

**TRANSITIONS FROM THE BRAIN INJURY SERVICES FUND TO CENTENNIAL CARE MCO**

The Brain Injury Services Fund (BISF) offers short-term non-Medicaid services to individuals with a confirmed diagnosis of brain injury, either traumatic brain injury (TBI) or other acquired brain injury (ABI). The MCO shall implement policies and procedures for ensuring that members with brain injury transition from the Brain Injury Services Fund (BISF) into benefits and services that are covered under the MCO. The MCO may contact the BISF Service Coordination Contractor to verify the status of a member’s BISF eligibility. At a minimum, the following must be addressed:

1. Maintain ongoing communication, enlist the involvement of, and coordinate with BISF Service Coordinators to effect the full transition of the member’s care from the BISF to the MCO. To effect the full transition of MCO members:
a. The HRA shall include questions about specific health diagnoses, including brain injury.
b. For members who identify as having brain injury during the HRA, opportunity shall be given to reschedule the HRA when natural supports and advocates, including a BISF Service Coordinator can be present. During any HRA, information shall be requested by the reviewer about the member’s specific needs and whether they are receiving services through the Brain Injury Service Fund or its currently contracted providers.
c. An HRA containing information about a self-reported brain injury shall trigger the scheduling of a CNA to include the person with the brain injury, any natural supports or advocates, and the BISF Service Coordinator or BISF Life Skills Coach, as applicable.
d. All parties are to ensure that a Release of Information has been signed by the member to effect the participation of the BISF Service Coordinator and/or other identified advocates in the member’s transition.
e. In the event that a BISF participant was assigned to an MCO and wishes to transfer to a different MCO, the Receiving MCO shall have the responsibility of working with the BISF Service Coordinator.
f. The MCO Care Coordinator is to acquire a copy of the BISF participant’s Confirmation of ICD-10 code and copies of any medical records entrusted to the BISF Service Coordinator to ensure their inclusion in the member’s file. These efforts are intended to preserve the history of brain injury and ensure that care needs related to the brain injury diagnosis can be readily implemented.
g. The MCO Care Coordinator shall maintain the primary responsibility for completing any transition paperwork but may request the assistance of the BISF Service Coordinator, as is mutually agreeable.
h. The MCO Care Coordinator shall assume the responsibility of assisting the member in setting up the services identified on the member’s Comprehensive Care Plan. The MCO Care Coordinator may consult with the BISF Service Coordinator regarding available service and community support providers.

2. Any additional recommendations made by the BISF Service Coordinator shall be noted in the member’s file.

3. Maintain continuity of care and implement the Care Plan services and supports that are needed to support the independent functioning of the member in their home and community. The following criteria for HSD’s Brain Injury Program to inactivate a BISF participant from the BISF shall apply for the full transition of a BISF participant into Centennial Care:
   a. The BISF participant assessed to not need Level 2 or Level 3 care coordination shall be inactivated from the BISF program at the end of the calendar month in which the MCO Care Coordination contact information was supplied, unless the BISF Service Coordinator supports that the determination was made in error. In this eventuality, BISF services may be continued to assist with the Fair Hearing
process, as described in the MCO’s denial letter.

b. A BISF Program Participant assessed at Level 2 or 3 shall not be inactivated from the BISF Program until the MCO Care Plan has been authorized by the MCO and the most critical services for addressing ADLs and behavioral health needs have been implemented (e.g., homemaker; home health aide, PT/OT/SLP, outpatient behavioral/mental health, etc.). All BISF services shall end upon the date of Comprehensive Care Plan authorization, unless critical services appearing on the MCO Care Plan have not yet been implemented. With respect to the denial of essential services deemed by the BISF Service Coordinator to be in error, BISF services may be continued to assist with the Fair Hearing process, as described in the MCO’s denial letter. The BISF Service Coordinator, BISF Life Skills Independence Coach, or other advocate may assist the MCO member with the Fair Hearing process.

c. Communication between the MCO Care Coordinator and BISF Service Coordinator shall continue during any Fair hearing process to facilitate transition efforts and the best outcome for the member.

d. Inactivation of the BISF participant shall not be delayed for any members who wish to self-direct their care, while agency-based managed care is ongoing. The MCO shall have the primary responsibility in assisting members who identify that they wish to self-direct their care. The MCO Care Coordinator and BISF Service Coordinator may work together in anticipation of a Self-Directed Community Benefit budget and SSP to meet the member’s anticipated needs.

4. Receive brain injury training by the HSD including but not limited to: general brain injury issues and available state and community resources; communication strategies; how to conduct assessments that capture the needs of brain injury; how to develop a Care Plan that considers the needs of members with brain injury. Training shall be required for any new Care Coordination staff within 3 months of employment, with renewed training to occur on a two year schedule.
5 TRANSITIONS OF CARE

Revision dates: August 15, 2014, March 1, 2017

Effective date: January 1, 2014

In managed care, HSD will continue its commitment to providing the necessary supports to assist members as they transition under various circumstances.

The MCOs must identify and facilitate coordination of care for all members during various transitions including but not limited to:

- From an institutional facility into the community;
- Between MCOs;
- From the hospital to their home; and
- From higher levels of care to lower levels of care

TRANSITIONS FROM A NURSING FACILITY TO THE COMMUNITY

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:

1. The comprehensive needs assessment
2. Preadmission Screen and Resident Review (PASRR)
3. Minimum Data Set (MDS)
4. Identification of wrap-around services
5. Provider referral
6. Ombudsman referral
7. Family member referral
8. Change in medical status;
9. Member self-referral
10. Community Reintegration Allocation received; and/or
11. State Agency Referral

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:

1. Facilitate the development of and implementation of a transition plan which must be labeled “Transition of Care Plan” and may be a stand-alone document or included in the Comprehensive Care Plan (CCP). If included as a part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing prior to the member’s discharge. The transition plan shall remain in place for a minimum of sixty (60) calendar days from the date of the decision to pursue transition or until the transition
has occurred. The transition plan shall address the Member’s transitional needs including but not limited to:

a. Physical and behavioral health needs;
b. Selection of providers of community services (i.e. meals on wheels);
c. Continuation of MAD eligibility;
d. Housing needs;¹
e. Financial needs;
f. Interpersonal skills;
g. Safety in the home environment; and
h. Community Transition Services through the Agency-Based Community Benefit (ABCB)

2. Administer the Comprehensive Needs Assessment (CNA) in the nursing facility to determine the community benefits and services upon the member’s discharge.

3. Conduct an additional assessment in the home within seventy-five (75) calendar days after transition to determine if the transition was successful and identify any remaining needs resulting in a new CCP or any modifications to the CCP.

4. If the member has an existing Full Medicaid category of assistance, other than Institutional Care, an allocation is not needed to reintegrate into the community. The reintegration process can be completed and Community Benefits can be provided with the Full Medicaid category.

5. If the member is Not Otherwise Medicaid Eligible (NOME), a Community Reintegration (CRI) allocation must be requested by contacting the Aging and Long Term Services Department, Aging and Disability Resource Center (ALTSD/ADRC), prior to discharge (see Section 7: Community Benefits). The care coordinator must assist the member in gaining eligibility for a Community Benefits category of assistance, and ensure services are authorized and in place for a safe and seamless discharge.

**TRANSITIONS FOR 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)

¹ Please see the CMS Standard Terms and Conditions for New Mexico’s 1115 Waiver.
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 comprehensive needs 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 must be labeled “Transition of Care Plan” and may be a stand-alone document or included in the Comprehensive Care Plan (CCP). If included as part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing. The transition plan 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:

1. Physical and behavioral health needs
2. Selection of providers in the community
3. Housing needs
4. Financial needs
5. Interpersonal skills; and safety

The care coordinator shall conduct an additional assessment in the home within seventy-five (75) calendar days after transition to determine if the transition was successful and identify any remaining needs resulting in a new CCP or any modifications to the CCP.

**TRANSITIONS OF CARE FOR MEMBERS MOVING FROM A HIGHER LEVEL 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:

1. 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.
2. 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.
3. 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.

**TRANSITIONS OF MEMBERS TURNING TWENTY-ONE (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 be labeled “Transition of Care Plan” and may be a stand-alone document or included in the CCP. If included as part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing. The transition plan must:

1. Establish a plan that is age appropriate and addresses the transition needs of the member:
   A. health condition management;
   B. developmental and functional independence;

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2 Please see the CMS Standard Terms and Conditions for New Mexico’s 1115 Waiver.
C. education;
D. social and emotional health;
E. guardianship; and
F. transportation

2. Ensure members and when authorized - family members, guardians and 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 the member, and when authorized – family members and guardian - 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 the member, and when authorized – the guardian 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.

TRANSITION FOR MEMBERS CHANGING MCOs WHILE HOSPITALIZED

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 thirty (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 fifteen (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.

TRANSITION FOR MEMBERS CHANGING MCOs 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.

TRANSITION FOR MEMBERS CHANGING MCOs WHILE 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.

**MCO REQUIREMENTS FOR MEMBERS TRANSITIONING BETWEEN MCOs**

For any member transitioning from one MCO to another the following must occur:

1. The relinquishing MCO must provide relevant information regarding members who transition to a receiving MCO.
2. The 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.
3. The receiving MCO 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 all other members (allows for care coordination on-site visit).
4. 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.
5. The relinquishing MCO that fails to notify the receiving MCO of transitioning members with special circumstances, or fails 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.
GENERAL INFORMATION This policy establishes guidelines and restrictions for all MCOs regarding nursing facility services. The Nursing Facility (NF) Medical Eligibility Criteria can be found at 8.312.2UR.

NURSING FACILITY’S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL

All requests for prior approval shall contain appropriate documentation and must be completed for each resident for every situation requiring prior approval. All requests for prior authorization are submitted to the resident’s MCO by fax.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability and related conditions. There are procedures and information that are applicable to all situations requiring prior approval.

1. Purpose of PASRR is as follows:
   A. To determine whether a resident requires a specific level of nursing care;
   B. To determine if there is suspicion of serious mental illness (MI) or intellectual disability/related condition (ID/RC);
   C. To assess persons suspected of having serious MI or ID/RC;
   D. To assess whether specialized services for MI or ID/RC are needed; and,
   E. To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program for those with MI or ID/RC.

2. Organization of the PASRR: PASRR is divided into two levels: Level I Screen and Level II Evaluation.
   A. Level I Screen: A Level I Screen must be completed prior to admission on every NF applicant. If, during the Level I Screen, it is determined that the individual is suspected of having either MI or ID/RC, a Level II Evaluation or PASRR waiver must occur prior to admission. A Level I Screen must also be done if there has been a significant change in the physical or mental condition of a resident who is suspected of having, or previously determined to have MI or ID/RC. “Significant change” for PASRR purposes can be tied to the already existing regulatory definition for significant change that prompts an alteration in a resident’s Minimum Data Set (MDS). Significant change referrals must be made to the PASRR Unit no later than twenty one (21) business days after the occurrence of the significant change. The PASRR Unit is required to review the completed Level I Screen packet within seven (7) to nine (9) business days of receipt of the
completed packet from the NF. Notification of the review decision must be submitted to the NF by phone or in writing within that time period.

B. Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having MI or ID/RC, a Level II Evaluation or a PASRR waiver must be completed prior to the admission of the resident. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident.

3. PASRR Waiver:
   A. If an individual falls within one of the following categories, a complete Level II Evaluation may not be performed. A PASRR Waiver is granted on a case-by-case basis.
      a. The resident has a primary diagnosis of dementia.
      b. The resident is being discharged from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed thirty (30) business days.
      c. The resident is suspected of having MI or ID/RC but is certified to be terminally ill with a life expectancy of six (6) months or less and is in need of continuous nursing care and/or medical supervision and treatment due to a physical condition.
      d. The severity of the resident’s medical condition and medical treatment needs are so extensive that specialized MI or ID/RC services are not likely to be beneficial.
      e. The resident who is suspected of having MI or ID/RC and is admitted directly to a NF from a home for very brief and finite stay (up to 14 days) for the purpose of providing respite to in-home caregivers.

4. Level I Screen Process
   A. A NF is required to submit copies of the Level I Screen for each resident with the MDS to the MCO/UR Contractor. The Screen and other necessary documentation must be sent with the MDS to avoid delays in the review process.
   B. The MCO/UR Contractor logs in the date on the recipient screen when the MDS, Level I Screen, and other documentation is received.
   C. The MCO/UR Contractor scans the Level I Screen. If the resident passes the Screen, the MCO/UR Contractor determines the NF LOC. If the resident fails the Screen, no further NF LOC action is to be taken by the MCO/UR Contractor. The MDS Screen, and other documentation, is submitted to the PASRR Unit.
   D. The MCO/UR Contractor then sends a notice to the NF that the MDS and other documentation have been sent to the PASRR Unit for a Level II Evaluation determination.
   E. The PASRR Unit reviews the Level I Screen, determines the NF LOC and sends a copy of the NF LOC, Screen, MDS and other documentation to the MCO/UR Contractor.

5. Level II Evaluation Process: The PASRR Program completes an evaluation and makes the Level II and NF LOC determination on the review portion of the MDS and returns the
MDS to the MCO/UR Contractor. All subsequent reviews are performed by the PASRR Unit unless waived by the PASRR Unit.

A. If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews are performed by the PASRR Unit instead of the MCO/UR Contractor.

B. If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for a NF LOC determination.

6. PASRR and Re-admission from a Hospital: The NF contacts the PASRR Program if the hospitalization of a resident results in a change in the Level I Screen.

7. PASRR and Medicaid Eligibility Pending: If a resident is in a “Pending Medicaid” status at the time of MDS submission and the resident fails the Level I Screen, the MDS is forwarded to the PASRR Unit as notification while the following actions occur:

A. The NF LOC determination is made.
B. The MAD 385 Form is completed and sent to the MCO/UR Contractor. The information on this form is processed by the MCO/UR Contractor and submitted to the appropriate ISD office and to the NF.
C. Once eligibility is established, the ISD office notifies the NF.
D. The NF must notify the PASRR Unit of the status of the resident’s eligibility.
E. The MDS which includes the Medicaid number and the certified length of stay is completed by the PASRR Unit.
F. Upon completion, the MDS is submitted to the MCO/UR Contractor.

**LEVEL OF CARE PACKET FOR NURSING FACILITIES INCLUDES:**

1. PASRR
2. NF LOC Notification Form - is the form used for all prior approval reviews.
   A. All requests for prior approval will be submitted on the NF LOC Notification Form.
   B. The NF should document what type of review is being requested at the top of the NF LOC Notification Form:
      a. Initial
      b. Continued Stay
      c. Medicaid Pending
      d. Transfer
      e. Re-admit
      f. Reconsideration
      g. All other required fields must be completed.

3. MDS
   A. An MDS and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.
   B. All locator fields must be clearly marked on the MDS.
C. When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process for the resident.

D. Appropriate documentation must accompany the MDS. Generally, appropriate documentation includes a valid order and must:
   a. Be signed by a Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant;
   b. Be dated; and
   c. Indicate the LOC – either high NF (HNF) or low NF (LNF).

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.

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.

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. The MCO shall review the documentation provided to determine the appropriate NFLOC. A packet that requests LNF but meets HNF criteria shall be upgraded to HNF; a packet that requests HNF but only meets LNF criteria shall be downgraded to LNF. A new doctor’s order is not required.

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, it 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; however, the MCO will continue to use the RFI process for requests reflecting that the individual may be eligible for HNF LOC. In the event that a determination is upgraded or downgraded from the physician’s order, the MCO shall give the NF technical assistance to educate the NF on determination criteria.

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

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 five (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.

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 (6) 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 (6) 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. 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.

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.

INITIAL DETERMINATION, REDETERMINATION, AND PENDING MEDICAID ELIGIBILITY

1. Initial Determination: All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the section NURSING FACILITY’S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission.
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.

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.

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.

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.

1. 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.

2. 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.

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.

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.

Reimbursement and retrospective reviews:

1. 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.
2. 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.

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.

CHANGED IN THE 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.
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.

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 NMAC.

COMMUNICATION FORMS

The MCO shall use the approved HSD forms for communication and notification with the NFs.
# Nursing Facility Level of Care Communication Form

*This Communication Form is intended to be used between MCO and Nursing Facilities ONLY.*

## I. Requestor Information

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<th>Date of Request</th>
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## II. Communication:

### Nursing Facility Resident Information:

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<th>NF Resident Name</th>
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</thead>
<tbody>
<tr>
<td>Resident DOB</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Resident SSN#</td>
<td>xxx – xx – Click here to enter text.</td>
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</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
- 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.
I. Nursing Facility Prior Authorization Request

### Nursing Facility Information

<table>
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<tbody>
<tr>
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<tr>
<td>Nursing Facility Name</td>
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<tr>
<td>NF Contact Name</td>
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</tr>
<tr>
<td>Nursing Facility Fax</td>
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<tr>
<td>Nursing Facility Phone</td>
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### Nursing Facility Resident Information:

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<tr>
<td>Resident SSN#</td>
<td>xxx – xx – Click here to enter text</td>
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<td>NF Admission Date</td>
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<tr>
<td>Selected MCO</td>
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<td>Resident Rep Name</td>
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<td>Rep Phone</td>
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<td>Resident Rep Address</td>
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### Requesting Service

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</tr>
<tr>
<td>Service End Date</td>
<td>Click here to enter a date.</td>
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### 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
  - Physician Progress Notes
  - History & Physical

II. Utilization Management (For MCO Use Only)

### Review Information

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<tr>
<td>NFLOC End Date</td>
<td>Click here to enter a date.</td>
</tr>
<tr>
<td>Approved Bed Begin Date</td>
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</tr>
<tr>
<td>Approved Bed End Date</td>
<td>Click here to enter a date.</td>
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</tbody>
</table>

### LNF Factors:

- Dressing
- Bathing
- Eating
- Meal Preparation
- Transfer
- Mobility
- Toileting
- Bowel/Bladder
- Daily Medication

### HNF Factors:

- Oxygen
- Orientation / Behavior
- Medication Administration
- Rehabilitation Therapy
- Skilled Nursing
- Feeding
- Mobility / Transfer

Approved NFLOC Type: Choose an item.

Comments: Click here to enter text.
7 COMMUNITY BENEFIT

Revision dates: August 15, 2014; March 1, 2016, March 1, 2017

Effective date: January 1, 2014

Community Benefits (CB) are services that provide assistance to individuals who 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 placement in a Nursing Facility (NF). Community Benefits do not provide 24-hour care and are intended as a supplement to an individual’s natural supports. Community Benefits are available to members meeting Nursing Facility Level of Care (NF LOC). The member’s Managed Care Organization (MCO) shall provide the Community Benefit as determined appropriate based on the Comprehensive Needs Assessment (CNA). Members eligible for the Community Benefit have the option of selecting Agency-Based Community Benefit (ABCB) or Self-Directed Community Benefit (SDCB).

Two eligibility components must be met prior to receiving CB: financial eligibility, determined by the Human Services Department/Income Support Division (HSD/ISD) and medical eligibility, determined by a MCO through a NF LOC assessment conducted as part of the CNA.

Members who have a Full Medicaid category of eligibility may be eligible for CB if they meet a NF LOC and indicate they have a need for CB. These individuals should request a CNA from their MCO to be assessed for CB. These individuals do not need an allocation to access CB (see Section 5 “Transitions of Care”).

DEFINITIONS

1. **Active Registration**: A registration is active if there is an open category of registration on the Central Registry.
2. **Activity of Daily Living (ADL)**: Tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting and transferring.
3. **Agency Based Community Benefits (ABCB)**: The Community Benefit services offered to a member who does not wish to self-direct his or her CB services.
4. **Allocation**: The opportunity given to a registrant who is not otherwise Medicaid eligible to apply for Community Benefits.
5. **Allocation Packet**: The documents sent by HSD/MAD/LTSSB to a registrant that includes the Letter of Interest, Primary Freedom of Choice, Withdrawal Form, Medicaid Application for Assistance, and a self-addressed stamped envelope.
6. **Central Registry**: A database that maintains a list of individuals who are interested in receiving Community Benefits and may be eligible for an allocation.
7. **Community Benefits (CB)**: Home and Community Based Services that provide long-term services and supports to eligible members that allow them to remain in the family residence, in their own home or in community residences such as an Assisted Living Facility.
8. **HSD 100**: “Medicaid Application for Assistance” that is used to apply for Community Benefits and is available on-line or at a local HSD/ISD office.

9. **Inactive Registration**: A registration is inactivated/closed under certain circumstances (see “Closing/Inactivating an Allocation”).

10. **Letter of Interest (LOI)**: The letter that is sent to a registrant informing him or her that an allocation is available and that he or she may apply for Community Benefits.

11. **Notice of Allocation (NOA)**: The letter that is sent to a registrant informing him or her that the PFOC was received at HSD/MAD/LTSSB and informs him or her of the next steps in the allocation process. The date of the NOA is the allocation date.

12. **Nursing Facility Level of Care**: The member'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 or assistance. A member must meet aNF LOC to be eligible for community benefit services.

13. **Primary Freedom of Choice (PFOC)**: The form included in the Allocation Packet that allows a registrant to confirm his or her interest in pursuing the opportunity to apply for Community Benefits.

14. **Self-Directed Community Benefits (SDCB)**: Community Benefit services offered to a member who is able to and who chooses to self-direct his or her CB services.

15. **Withdrawal Form**: The form that is contained in the Allocation Packet that allows a registrant to withdraw his or her request to apply for Community Benefits.

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**REGISTRATION FOR THE COMMUNITY BENEFIT FOR MEMBERS NOT OTHERWISE MEDICAID ELIGIBLE (NOME)**

The Aging and Long Term Services Department/Aging and Disability Resource Center (ALTSD/ADRC, referred to as ADRC from this point forward) manages the Centennial Care Central Registry by enrolling individuals, completing the pre-assessment, assigning the category of registration, and sending Exception requests to HSD/MAD/LTSSB. Any individual has the right to place his or her name on the Central Registry if: (1) it has been determined that the individual is not currently Medicaid eligible; or (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, the ADRC shall refer the individual to his or her MCO.

Any individual has the right to register for multiple waivers at the same time. Individuals may place his or her name on the Central Registry by calling or appearing in person to the ADRC. An individual must be a resident of the state of New Mexico in order to be registered. Residency is determined based on the State’s eligibility rule for Medicaid. It is the individual’s responsibility to inform the ADRC of any changes in address and/or telephone number so the Central Registry can be updated. Individuals are also encouraged to contact the ADRC if they have significant
changes in their health or residential situation. These circumstances may affect their type of registration.

Individuals should note that the Central Registry records information such as: (1) the applicant’s demographic information; (2) the date of registration; and (3) the applicant’s specific long term care needs. Individuals are also required to complete a pre-assessment which aids the ADRC staff in directing the applicant to the appropriate category of registration: Community Reintegration, Expedite, and Regular. The registration types are defined as follows:

A. Community Reintegration (CRI) – provides individuals the opportunity to move out of a nursing facility (NF) and back into the community for a registrant who is in a NF at the time of registration. In order to be eligible for CRI, the registrant must have resided in a NF for 90 consecutive days. Within the 90 days, the registrant could have been hospitalized and returned to the NF, for the remainder of the 90 days. The individual participating in the community reintegration 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 or her home. The intent of CRI is to assist the individual to become integrated into his/her community and be as independent as possible. The MCO must be able to ensure a reasonable level of health and safety for the member while ABCB services are being provided. ABCB services must be cost-effective and must not exceed the average annual per capita costs of Nursing Facility services as determined by The Human Services Department (HSD).

CRI registration for the ABCB can be completed by calling the ADRC. Once a continuous 90 day stay is confirmed by the HSD/MAD/LTSSB and funding is available, a community re-integration allocation is granted. The HSD/MAD/LTSSB sends the allocation packet to the registrant/representative. The allocation paperwork must be returned to the HSD/MAD/LTSSB within 45 calendar days or the allocation will be closed and the registrant will need to re-register on the Central Registry and wait for another allocation. If an extension is needed, HSD/MAD/LTSSB must be notified to grant the extension (see “The Allocation Process: Timelines for the Allocation Packet”).

Once the PFOC and HSD 100 are received by HSD/MAD/LTSSB, the allocation is processed (see “The Allocation Process: Processing PFOCs”). Once the allocation has been granted, it is the MCO’s responsibility to ensure services are authorized and in place prior to discharge so the registrant will have a safe and appropriate discharge.

The MCO must contact the registrant within 5 business days of receipt of the PFOC to schedule an initial assessment to determine medical eligibility. The assessor explains the
CRI process to the registrant/representative. If the registrant/representative wishes to remain in the institution, the Withdrawal Form must be completed, signed and mailed to HSD/MAD/LTSSB. If the registrant/representative wishes to proceed with the eligibility process, the MCO proceeds with the medical eligibility process.

B. Expedite (EXP) – a registrant who has an urgent need for care. To be eligible, the registrant must:
   a. be pre-assessed by the ADRC to require total assistance in at least three (3) categories of ADLs and
   b. score a minimum of 48 points on the ADRC pre-assessment.

C. Regular (REG) – a registrant who does not meet the criteria for any of the other registration types, based upon the ADRC pre-assessment.

Individuals may request an Exception to their category of registration and request an Expedited allocation to the ADRC, under extreme circumstances. The ADRC will send the request to the HSD/MAD/LTSSB who will consider issuing an Expedited allocation. The following are examples of circumstances that may warrant an exception request for an Expedited allocation:

   a. to ensure continuity of care, an individual was receiving Community Benefits under a Full Medicaid category of assistance and has had his or her Full Medicaid eligibility terminated. An individual must inform the ADRC that he or she has lost his or her Full Medicaid category of assistance, and was receiving Community Benefits. The request must be made to ADRC within six (6) months of termination of the Full Medicaid category of assistance.
   b. an individual who was in a NF for 90 consecutive days and was not registered for a CRI allocation prior to discharge. The request must be made to ADRC within three (3) months after discharge from the NF.
   c. an individual is residing in an Assisted Living Facility and can no longer afford the private pay;
   d. an individual has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC);
   e. an individual who no longer qualifies for the Medically Fragile Waiver and is ventilator dependent; or
   f. an individual who meets the hardship criteria such as an extreme health and safety risk, and has been referred to the ADRC by the HSD or the ALTSD/Adult Protective Services (APS).
THE ALLOCATION PROCESS

The ADRC manages the Central Registry by enrolling individuals, completing the pre-assessment, and sending Exception requests to HSD/MAD. The HSD/MAD/LTSSB manages the allocation process by mailing Allocation Packets to registrants and forwarding completed allocation paperwork to HSD/ISD and to the MCO.

In order to facilitate the allocation process, the ADRC shall:

1. Maintain accurate registrant information in the Central Registry, including coding of category of registration for each registrant; and
2. Change a registrant’s category of registration, if the ADRC obtains information that justifies the change, e.g., a registrant leaves a NF before the 90-day requirement is met.

When the HSD/MAD Director determines that a regular allocation should be released, the allocation process begins by sending the Allocation Packet 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”) and HSD 100, or a Withdrawal Form.

The Allocation Packet contains the:

1. Letter of Interest (LOI);
2. PFOC;
3. Withdrawal Form;
4. HSD 100 “Medicaid Application for Assistance”;
5. Community Benefits Informational Brochure; and


Timeframes for the Allocation Packet:

1. The registrant has 45 calendar days to return either a completed PFOC and HSD 100, or a Withdrawal Form to HSD/MAD/LTSSB.
2. The registrant may request a one-time extension to return the PFOC and HSD 100, or Withdrawal Form by contacting the HSD/MAD/LTSSB, and if requested, it shall be granted for up to thirty (30) calendar days. Any additional time (extensions) requested by the registrant must be made directly to HSD/MAD/LTSSB for approval.
3. If there is no response to the Allocation Packet either after the original 45 calendar days or after the expiration of any granted extensions, HSD/MAD/LTSSB shall send a closure letter to the registrant’s mailing address on file.

Processing PFOCs:
Once HSD/MAD/LTSSB receives the PFOC and the HSD 100, HSD/MAD/LTSSB will review the documents to ensure that they are complete and signed by the registrant.

1. If the PFOC and/or HSD 100 are not complete and/or signed, the document(s) will be returned to the registrant, identifying the information required, and providing the registrant up to thirty (30) calendar days to complete and return them. Failure to return the document(s) within the 30 calendar day time period will result in closure as described herein.

2. If the PFOC and HSD 100 are complete, HSD/MAD/LTSSB will process them and

   A. send a Notice of Allocation (NOA) letter to the registrant with a copy of the PFOC, for their records;
   B. send a copy of the NOA, PFOC, and HSD 100 to the HSD/ISD Eligibility system; and
   C. send a copy of the NOA and PFOC to the registrant’s MCO.

**ELIGIBILITY**

Once the PFOC and HSD 100 have been distributed to HSD/ISD and the MCO, HSD/MAD/LTSSB’s “Processing PFOCs” is complete. HSD/MAD/LTSSB is unable to assist with medical or financial eligibility. Registrants must meet two (2) types of eligibility, initially and annually, to receive and continue receiving Community Benefits:

1. Medical Eligibility: The medical eligibility determination is completed by the MCO. In order to be medically eligible, the registrant must meet NF LOC. In addition, the CNA must indicate that the registrant has a need for Community Benefits.
   A. The NF LOC shall be determined within 60 calendar days from the MCO’s receipt of the PFOC.
   B. The MCO shall submit the NF LOC approval to HSD/ISD, via the interface file, upon NF LOC determination so it can be used by HSD/ISD to complete eligibility process.
   C. The MCO shall submit the NF LOC denial to HSD/ISD, via the interface file, within 5 business days of the NF LOC denial determination.
   D. The MCO shall submit the NF LOC effective dates and applicable Setting of Care of ADB (Agency Directed Services) to the Omnicaid system, via the interface file, within 5 business days of receiving the member’s initial enrollment on the Enrollment Roster file.
   E. If a current NF LOC is already in place upon receipt of the PFOC, a new one does not need to be completed by the MCO, unless there are less than 120 calendar days remaining on the existing NF LOC.

2. Financial Eligibility: In order to be financially eligible, income must be under the Institutional Medicaid (ICM)/Waiver maximum allowable amount. In addition, all other financial and non-financial eligibility requirements must be met as determined by
HSD/ISD.

The registrant must complete both the medical and financial eligibility within 90 calendar days from the allocation date stated in the NOA. Failure to complete both the medical and financial eligibility within the 90 calendar day time period shall result in closure of the allocation. If a registrant needs additional time to submit required documentation, the request must be submitted directly to HSD/ISD.

Once eligibility is approved by HSD/ISD, registrants will be enrolled with ABCB services and shall receive such services as are needed, based on the CNA conducted by the member’s MCO.

The member must participate in the Agency Based Community Benefit (ABCB) service delivery model for a minimum of 120 calendar days before the member can switch to the Self-Directed Community Benefit (SDCB) service delivery model. A member must contact their MCO Care Coordinator to discuss the switch from ABCB to SDCB. The Community Benefit services are described in the MCO Policy Manual in Sections 8 and 9.

**CLOSING/INACTIVATING AN ALLOCATION**

An allocation will be inactivated by HSD/MAD/LTSSB if one of the following occurs:

1. The registrant returns a signed Withdrawal Form;
2. The registrant does not return the PFOC within the required timeframes;
3. The ADRC or HSD/MAD/LTSSB is informed that the registrant intends to remain in the NF;
4. The ADRC or HSD/MAD/LTSSB is informed that the registrant is no longer a resident of the State of New Mexico;
5. The ADRC or HSD/MAD/LTSSB has been notified that the registrant has expired;
6. The Allocation Packet is returned as undeliverable and no other contact information is available; or
7. The registrant has a Full Medicaid category of eligibility and has access to Community Benefit services through their MCO.

**REGISTRANT NOTICE REQUIREMENTS**

The registrant is notified by letter in the following circumstances:

1. New registration;
2. When the State is unable to contact the registrant by telephone;
3. When an allocation becomes available for the registrant (Allocation Packet);
4. When an allocation is complete (Notice of Allocation); and
5. When a registration is closed/inactivated for any reason other than a completed allocation.
When the State has been notified that the registrant is deceased, a letter will not be sent to the registrant or the registrant’s representative.

**UNDELIVERABLE NOTICE**

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

The Agency-Based Community Benefit (ABCB) is intended to provide a community-based alternative to institutional care.

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

DEFINITIONS AND ACRONYMS

1. **Adult**: Individuals who are twenty-one (21) years of age or older.
2. **Allocation**: Funding becomes available to serve additional individuals on the 1115 waiver who are not otherwise Medicaid eligible.
3. **Annual**: The 12-month period covered by a Care Plan, except where otherwise stated.
4. **Adult Protective Services Division (APS)**: Adult Protective Services Division of the Aging and Long-Term Services Department.
5. **Care Coordinator (CC)**: The individual responsible for coordinating services with members in the managed care program.
6. **Child**: An individual under twenty-one (21) years of age.
7. **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.
8. **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.
9. **Children Youth and Families Department (CYFD)**: Children Youth and Family Department.
10. **Face - to - Face**: Being in the physical presence of the individual who is receiving services.
11. **Freedom of Choice**: A form that provides the member opportunities to select their choice for delivery of services as identified on the Care Plan.
12. **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.

13. **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 ABCB Services for populations that meet the Nursing Facility Level of Care (Disabled & Elderly, Brain Injury, and AIDS).

14. **Interdisciplinary Team (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.

15. **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.

16. **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.

17. **Income Support Division (ISD)**: Income Support Division, New Mexico Human Service Department.

18. **Level of Care (LOC)**: Level of Care, an instrument used in determining the level of care (medical eligibility) for Community Benefit Services and for institutional care.

19. **LTCMA**: Long-Term Care Medical Assessment (ISD 379).

20. **MAD**: The Medical Assistance Division, New Mexico Human Services Department.

21. **Natural Family Member**: A person related by blood or adoption to include: mother, father, brother, sister, aunt, uncle, grandmother, grandfather, son, or daughter.

22. **Natural Home**: Residence of the individual or the primary caregiver.

23. **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.

24. **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).

25. **Parent**: Natural or adoptive mother or father, or stepmother, stepfather.

26. **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.

27. **Primary Caregiver**: Parent or surrogate parent providing day-to-day care of an individual.

28. **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.
29. Support: Assistance to an individual that may or may not include a paid service.

AGENCY BASED COMMUNITY SERVICES REQUIREMENTS

These requirements apply to the services provided through the Medicaid 1115 Waiver for individuals who meet the eligibility criteria for Home and Community-Based Services (HCBS), Agency Based Community Benefit Services (ABCB). These requirements clarify, interpret, and further enforce 8.308.12 NMAC, Managed Care Program, Community Benefit, effective January 1, 2014.

ABCB providers must meet all Federal requirements for home and community-based service providers.

The requirements address each service covered by the ABCB. Individuals served through this program will expect to receive services that meet these standards. Centennial Care MCOs must contract with eligible ABCB providers before rendering Community Benefits to members. Eligible ABCB providers are those that have been approved and certified by the HSD/MAD Long Term Care provider enrollment unit, per 8.308.2.9 NMAC Managed Care Program, Provider Network, effective January 1, 2014.

These requirements 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 (24) 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 person-centered Care Plan as developed with the member and the MCO Care Coordinator (CC). The person-centered Care Plan must revolve around the individual ABCB member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living.

Home and Community-Based settings shall meet the following requirements:

1. are integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
2. are selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting
options are identified and document in the person-centered service plan and are based on
the individual’s needs, preferences, and, for residential settings, resources available for
room and board;
3. ensure an individual’s rights of privacy, dignity and respect, and freedom from coercion
and restraint;
4. optimize, but do not regiment, individual initiative, autonomy, and independence in
making life choices, including but not limited to, daily activities, physical environment,
and with whom to interact; and
5. facilitate individual choice regarding services and supports, and who provides them.

ABCB COVERED SERVICES

1. All ABCB services are subject to the approval of the MCO/UR. Below is a list of ABCB
covered services for members in ABCB, followed by detailed service descriptions:
   • Adult Day Health
   • Assisted Living
   • Behavior Support Consultation
   • Community Transition Services
   • Emergency Response
   • Employment Supports
   • Environmental Modifications
   • Home Health Aide
   • Personal Care – Consumer Directed
   • Personal Care – Consumer Delegated
   • Private Duty Nursing
   • Respite RN
   • Respite
   • Skilled Maintenance Therapy 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 into the Care Plan. Adult Day Health settings must be integrated
and support full access of individuals receiving Medicaid HCBS to the greater community,
engage in community life, control personal resources, and receive services in the community, to
the same degree of access as individuals not receiving Medicaid HCBS. The services are
generally provided for two (2) or more hours per day on a regularly scheduled basis, for one (1)
or more days per week, by a licensed adult daycare, community based facility that offers health
and social services to assist participants to achieve optimal functioning. Private Duty Nursing
services and Skilled Maintenance Therapies (physical, occupational and speech) may be
provided in conjunction with Adult Day Health services, but the Adult Day Health provider or by another provider. Private duty nursing and therapy services must be provided by licensed nurses and therapists. The Private Duty Nursing and Skilled Maintenance Therapies must be provided in a private setting at the facility. Meals provided as part of this service shall not constitute a “full nutritional regime” (3 meals per day). Transportation to and from the Adult Day Health Center must be coordinated by the Adult Day Health program.

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:
      a. Coordination of transportation to and from the Adult Day Health center.
      b. Activities that promote personal growth.
      c. Activities that enhance the member’s self-esteem by providing opportunities to learn new skills and adaptive behaviors.
      d. Supervision of self-administered medication as determined by the New Mexico Nurse Practice Act.
      e. Activities that improve capacity for independent functioning.
      f. Activities that provide for group interaction in social and instructional programs and therapeutic activities.
      g. Personal care services.
      h. Meals that do not constitute a “full nutritional regime” of three (3) meals per day.
      i. Intergenerational experiences.
      j. Involvement in the greater community.
      k. 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 healthy 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. A 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:
      a. Learn new skills and adaptive behaviors.
b. Improve or maintain the capacity for independent functioning.
c. 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. In order to be approved and certified by the HSD/MAD Long Term Care provider enrollment unit, Adult Day Health Centers must be operating with a fully approved permanent license. Incomplete applications to the HSD/MAD Long Term Care provider enrollment unit shall be rejected and not considered for review until a complete application is submitted.
   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 (2) hours per day for one (1) 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 lifestyle.
- 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:

a. Personal Hygiene.
b. Dressing.
c. Eating.
d. Socialization.
e. Opportunities for individual and group interaction.
f. Housekeeping.
g. Laundry.
h. Transportation.
i. Meal preparation and dining.
j. Twenty-four (24) hour, on-site response capability to meet scheduled or unpredictable participant needs.
k. Capacity to provide on-going supervision of the ABCB member within a twenty-four (24) hour period.
l. Coordination of access to services not provided directly.
m. Participation in the Interdisciplinary Team meetings for development of the Care Plan.
n. Implementation of the plan to meet the needs, evaluation for effectiveness, and adaptation as needs change.

o. 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.

p. 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:

1. Private Duty Nursing services for Adults (see the ABCB Service Standards for Private Duty Nursing).
2. Skilled Maintenance Therapies for Adults (see the ABCB Service Standards for Skilled Maintenance Therapies).
3. 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. In order to be approved and certified by the HSD/MAD Long Term Care provider enrollment unit, Assisted Living facilities must be operating with an approved permanent license. 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.).

C. 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.).

D. 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 Plan of Care.
E. 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.

F. 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. Members shall be afforded the same protections from eviction as all tenants under landlord law of state, county, city or other designated entity. 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.

G. 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:
   
a. 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.
   b. 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.
   c. 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.
   d. Kitchens must be furnished with a sink, a refrigerator; at least a two burner stove top or 1.5 cubic foot microwave oven.
   e. Each unit must be equipped with an emergency response system.
   f. Common living areas must be smoke free.
   g. Floor plans must be submitted to the HSD/MAD along with the Medicaid Provider Participation Application or renewal.
   h. In addition CMS requires residential settings located in the community to provide members with the following:
      1. Private or semi-private bedrooms including decisions associated with sharing a bedroom: Full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas; All participants must be given an option to receive home and
community based services in more than one residential setting appropriate to their needs; Private or semi-private bathrooms that include provisions for privacy; Common living areas and shared common space for interaction between participants, their guests, and other residents; Members must have access to food storage or food pantry area at all times; Members must have the freedom and support to control their own schedules regarding their day to day activities including having visitors of their own choosing at any time, when and what to eat, in their home and in the community; Members will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, have easy access to resources and activities of their choosing in the community.

2. In provider owned or controlled residential settings, the following additional conditions will be provided to members: Privacy in sleeping or living unit; units have lockable entrance doors, with members and appropriate staff having keys to doors; Members share units only at the member’s choice and have a choice of roommates in that setting; Members have freedom to furnish and decorate sleeping or living units as specified in the lease or agreement; The setting is physically accessible to the member.

3. Any modification of the above conditions must be supported by a specific need and justified and documented in the Plan of Care to address the following:
   a. identify a specific and individualized assessed need;
   b. document the positive interventions and supports used prior to any modifications to the Plan of Care;
   c. document less intrusive methods of meeting the need that have been tried but did not work;
   d. include a clear description of the condition that is directly proportionate to the specific assessed need;
   e. include regular collection and review of data to measure the ongoing effectiveness of the modification;
   f. include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
   g. include the informed consent of the individual; and
   h. include an assurance that interventions and supports will cause no harm to the individual.

3. REIMBURSEMENT
The billable unit rate for Assisted Living services is based on a daily rate.

A. Room and Board
   a. The Agency Based Community Benefit does not reimburse for room and board costs for the member (such as rent, groceries, etc.).
   b. 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.
   c. The provider agency must comply with all state and federal guidelines regarding the establishment of room and board rates to the ABCB services recipients.
   d. Training on member specific issues is reimbursable.

B. Non Billable Activities
   a. The Assisted Living Services provider will not bill MCO for Room and Board.
   b. General training requirements are an administrative cost and not billable.
   c. 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 member and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the member include: assessments, evaluations, treatments, interventions, follow-up services and assistance with challenging behaviors and coping skill development. Services for the parents, family members and DSPs include training in dealing with challenging behaviors and assistance with coping skill development at home and in the community.

1. SCOPE OF SERVICES
   A. 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.

B. Behavior Support Consultation Services Include:
   a. 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.
   b. Designing, modifying and monitoring the use of related activities for the
      participant/participant representative that is supportive of the Care Plan.
   c. Training families and DSPs in relevant settings as needed for successful
      implementation of therapeutic activities, strategies, and treatments.
   d. Consulting with the Interdisciplinary Team (IDT) member(s), guardians,
      family, or support staff.
   e. 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.
   f. 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.
   g. Services may be provided in a clinic, home, or community setting.

C. Comprehensive Assessment Guidelines:
   a. 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.

D. Attendance at the IDT Meeting:
   a. The BSC is responsible for attending and participating, either in person
      or by conference call in IDT meetings convened for service planning.
   b. 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.
   c. 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.
E. Discharge Planning Documentation Includes:
   a. Reason for discontinuing services (such as failure to participate, request from participant/participant representative, goal completion, and/or failure to progress).
   b. Written discharge plan shall be provided to the participant/participant representative and the MCO Care Coordinator by the BSC.
   c. Strategies developed with participant/participant representative that can support the maintenance of behavioral support activities.
   d. Family and direct support professional training that is completed in accordance with the written discharge plan.
   e. 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.

F. Agency/Individual Provider Requirements
   a. All BSCs who are working independently, or as employees of a provider agency who offer behavior support consultation services shall meet all the requirements of the ABCB Service Standards.
   b. The agency must maintain a current provider status through the HSD/MAD Provider Enrollment Unit. Contact Provider Enrollment Unit for details.

G. Agency/Individual Administrative Requirements
   a. BSC Requirements:
      1. 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.
      2. 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).
      3. 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.
      4. Licensed BSCs identified in Section III. A. of this document may provide billable behavior support consultation services.

H. Documentation:
   a. Documentation must be completed in accordance with applicable HSD/MAD and federal guidelines.
b. 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.
c. Verified Electronic Signatures may be used. BSC name and credential(s)
typed on a document is not acceptable.
d. All documentation will be signed and dated by the BSC providing
services.
e. 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.
f. 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.
g. 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.
h. Any modifications that need to be included in the Care Plan must be
coordinated with the MCO Care Coordinator.
i. 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.
j. Each participant will have an individual clinical file maintained by the
provider.
k. Review Physician/Healthcare provider orders at least annually and as
appropriate, and recommend revisions on the basis of evaluative finding.
l. Copies of BSC contact notes and BSC documentation may be requested
by HSD/MAD for assurance purposes.

I. 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:

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

COMMUNITY TRANSITION SERVICES

Community Transition Services are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a skilled nursing facility to a living arrangement in the community where the person is directly responsible for his or her own on-going living expenses. This service is not intended to cover the household costs of the member’s natural supports.

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

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.
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:
      a. Installation, testing and maintenance of equipment.
      b. Training on the use of the equipment to members/caregivers and first responders.
      c. 24-hour monitoring for alarms.
      d. Monthly systems check, or more frequently if electrical outages, severe weather systems, etc. warrant more frequent checks.
      e. 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.

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. Employment Supports settings must be integrated and support full access of individuals receiving Medicaid HCBS to the greater
community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and provide access to services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. 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:

a. **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.

b. **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:
   a. Quarterly progress reports.
   b. 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.
   c. 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:
   a. The Supported Employment Provider Agency shall submit the following to the MCO Care Coordinator:
      b. Quarterly Progress Reports based upon the individual’s Care Plan cycle;
      c. Vocational Assessment; and
      d. 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):
   a. 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.
   b. 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.

c. 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:

a. Provide supports to the individual as contained in the Care Plan to achieve his or her outcomes and goals;

b. Employ job-coaching techniques and to help the individual learn to accomplish job tasks to the employer’s specifications;

c. Increase the individual’s capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;

d. 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;

e. Identify specific information about the individual’s interests, preferences and abilities;

f. 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;

g. 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;

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

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

j. 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;

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

l. Model behavior, instruct and monitor any work place requirements to the individual;
m. Adhere to professionally acceptable business attire and appearance, and communicate through interactions a business-like, respectful manner; and

n. 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 (PPA). 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 SERVICES**

   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.

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 or higher 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.
   a. The environmental modification provider will submit the following information and documentation to the MCO:
      1. Environmental modification evaluation;
      2. 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);
      3. Letter of Acceptance of Service Cost Estimate signed by the member;
4. 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;
5. 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;
6. 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:
   a. Letter of Approval of Work completed signed by the member; and
   b. Photographs of the completed modifications.

J. The MCO must submit the following information to the provider:
   a. Care Coordinator Individual Assessment of Need.

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 (PPA). Billing is on a project basis, one (1) unit per environmental 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.
   C. 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.
   D. New Construction: This service cannot be used to fund apartment buildings and Assisted Living facilities.

HOME HEALTH AIDE

Home Health Aide Services provide total care or assist an eligible member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake.
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:
      a. 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;
      b. 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;
      c. 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.
      d. 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.
      e. 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.
      f. 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:
   a. Service received;
   b. Member’s status;
   c. Contact with family members;
   d. Review of HHA plan of care with appropriate modification annually and as needed.

D. Requirements for the HH Agency Serving ABCB Population:
   a. 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.
   b. 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.
   c. The HH Agency will document and report any noncompliance with the Care Plan to the MCO Care Coordinator.
   d. 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.
   e. 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.
   f. 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.
   g. 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.
   h. 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 (PPA). 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

1. SCOPE OF SERVICES

Personal Care Services (PCS) have been established by the New Mexico Human Services Department (HSD) Medical Assistance Division (MAD or Medicaid) to assist individuals 21 years of age or older who are eligible for full Medicaid coverage and meet the nursing facility (NF) level of care (LOC) criteria. 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 a task 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.

D. PCS providers will use the HSD approved Electronic Visit Verification (EVV) system to record date and time for provided PCS.

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/Individuals with Intellectual Disabilities (ICF/IID) Medicaid, PACE, or Adult Protective Services attendant care program, at the time PCS are furnished; an individual residing in a NF or ICF/IID Medicaid is eligible to apply for PCS to facilitate NF discharge; recipients of community transition goods or services may also receive PCS; all individuals must meet the Medicaid eligibility requirements to receive PCS; the MCO, Medicaid or its alternative
designee must conduct 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 – Consumer-Delegated PCS and Consumer-Directed PCS
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. The MCO’s care coordinator is responsible for explaining both models to each consumer, initially, and annually thereafter.

a. 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.
b. 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.

5. CONSUMER’S RESPONSIBILITIES

A. 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:
      1. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
      2. Allowing the PCS provider to complete monthly home supervisory visits;
      3. Participating in the CNA process, at least annually, in the consumer’s primary place of residence;
      4. Participating in the development and review of the IPoC;
      5. 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
      6. 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:
   a. Interviewing, hiring, training, terminating and scheduling personal care attendants; this includes, but is not limited to:
      1. 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;
      2. 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
      3. Identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);
   b. 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;
c. 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;
d. 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;
e. 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;
f. 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. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver’s termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agencies standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.
g. 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;

h. 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 the consumer’s MCO 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 the consumer’s MCO 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;

i. 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;

j. 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.;

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

l. Allowing the PCS provider to maintain at least a minimum of quarterly in-person contact;

m. Participating in the CNA process, at least annually, in the consumer’s primary place of residence; Participating in the development and review of the IPoC;

n. 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;

o. 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.

C. 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:

   1. Medicaid’s PCS provider rules and regulations;
   2. Personnel policies; and
   3. Office details that include but are not limited to:
i. 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;

ii. Meeting all Americans with Disabilities Act (ADA) requirements; and

iii. 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:
   1. Service delivery;
   2. Operational activities;
   3. Critical incident and significant events management practices;
   4. Quality improvement action plan; and
   5. 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; 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:
   1. Communication skills;
   2. Patient/member rights, including respect for cultural diversity;
   3. Recording of information for patient/client records;
   4. Nutrition and meal preparation;
   5. Housekeeping skills;
   6. Care of the ill and disabled, including the special needs populations;
   7. Emergency response (including CPR and first aid);
   8. Universal precautions and basic infection control; Home safety including oxygen and fire safety;
   9. Incident management and reporting; and
10. Confidentiality.

j. 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:

1. Attend a mandatory Medicaid or its designee’s provider training session prior to the delivery of PCS; and
2. Possess a letter from Medicaid or its designee changing provider status from “pending” to “active”.

k. An agency will not be certified as a personal care agency if:

1. 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;
2. 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 grandparents, 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.

D. 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:

a. Furnishing services to Medicaid consumers that comply with all specified Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies and 8.308.2.9 NMAC, Provider Network Policies;
b. 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;

c. Use the HSD approved EVV system;

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

e. 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;

f. The PCS agency will, unless exempted by MAD or its designee, use an electronic system that attendants will 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.

g. 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;

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

i. 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;

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

k. 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. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver’s termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agencies standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.

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

m. 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/Individuals with Intellectual Disabilities (ICF/IID), 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.

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

o. 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;
p. 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:

1. 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;
2. Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;
3. 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;

q. 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:

1. Death of the consumer:
   i. Unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause;
   ii. 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;

2. Other reportable incidents:
   i. Environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;
   ii. 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;
   iii. 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;
   iv. Any reports made to Adult Protective Services (APS);
r. Informing the consumer and his/her attendant of the responsibilities of the agency;
s. Develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;
t. Provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;
u. 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
v. Maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable.

E. For agencies providing PCS under the consumer-directed model, the responsibilities include:
   a. 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;
      1. 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
      2. 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;
   b. 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;
   c. 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; however; the agency must maintain at least quarterly in-person contact with the consumer; a copy of the signed agreement must be maintained in the consumer’s file;
   d. 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;

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

f. 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;

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

h. 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;

i. 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

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

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

   a. Employing, terminating and scheduling qualified attendants;

   b. 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:

      1. An overview of PCS;

      2. Living with a disability or chronic illness in the community;

      3. CPR and first aid training; and

      4. 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;
5. Documentation of all training must include at least: name of trainee, title of the training, source, number of hours, and date of training;

6. 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;

c. 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;

d. 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;

e. 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;

f. Complying with federal and state labor laws;

g. Preparing all documentation necessary for payroll;

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

i. 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;

j. 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;

k. 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;
l. Establishing and explaining to all their consumers and all attendants the
necessary documentation needed for reimbursement of PCS;
m. Performing payroll activities for the attendants;
n. Providing workers’ compensation insurance for attendants;
o. 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:
1. Date of visit;
2. Time of visit to include length of visit;
3. Name and title of person conducting supervisory visit;
4. Individuals present during visit;
5. Review of IPoC;
6. Identification of health and safety issues and quality of care
   provided by attendant, and
7. Signature of consumer or consumer's legal representative;
p. Maintaining an accessible and responsive 24-hour communication system
for consumers to use in emergency situations to contact the agency;
q. Following current recommendations of DOH and CDC, as appropriate, for
preventing the transmission of TB; and
r. 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.
G. 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:
a. Being hired by the consumer (consumer-directed model) or the PCS
   agency (consumer-delegated model);
b. Not being the spouse of a consumer, pursuant to 42 CFR Section 440.167
   and CMS state Medicaid manual section 4480-D;
c. 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;
d. Being 18 years of age or older;
e. 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;
f. 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. The agency is responsible for the cost of the first criminal history screening and the member and/or caregiver is responsible for any additional caregiver history screenings and the associated costs thereafter if the caregiver’s termination of employment is a result of termination on behalf of the member for an unjustifiable reason not related to the agencies standard employment conditions. If the caregiver quits or termination is a result of the caregiver failing to meet standard employment conditions outlined by the agency, the agency will be responsible for the criminal history screening for the next hired caregiver.
g. 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;
h. May not be the consumer's representative, unless he/she is also the legal representative;
i. 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);

j. 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;

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

l. 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.

H. 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.

a. 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.

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

c. 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:

1. 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

2. 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.

I. 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 devices(s) such as walkers, canes, and wheelchairs, or changing position to prevent skin breakdown.
a. 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.

b. 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.

c. Description of PCS refers to 8.308.12.13 NMAC.

J. 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.

a. 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.

b. 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.

c. Any relevant sections of the CNA and the personal care service allocation tool is sent to the PCS agency by the MCO to allow the PCS agency to develop the IPoC.

d. 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:

   1. There is a change in the consumer’s condition (either improved or declined);
   2. There is a change in the consumer’s natural supports or living conditions;
   3. Upon the consumer’s request;
   4. The MCO must explain each service delivery model at least annually to consumers enrolled in Agency Based Community Benefits (ABCB).

e. 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.

f. 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.
g. 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.

h. 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.

K. 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 PCS agency, with the consumer’s consent, may use the authorized allocation of hours in an individualized schedule. The individualized schedule of services allows the consumer and PCS agency flexibility while maintaining a focus on the consumer’s health and safety. The IPOC will clearly document the consumer’s consent to the schedule. The PCS agency and consumer will develop the schedule for the number of days-per-week and hours-per-day to complete the needed ADL and IADL assistance. The PCS agency shall establish the appropriate monitoring protocols to ensure this flexible schedule does not adversely affect the consumer’s health and safety.

Should the MCO determine, based on care coordination, IPOC reviews, or other quality oversight that the IPOC does not adequately meet the consumer’s needs or has created a health and/or safety concern, the MCO will communicate a request to the PCS Agency that the IPOC will need to be adjusted to ensure the consumer’s care needs are met. The PCS agency will follow the standard IPOC process utilizing the PCS Allocation Tool and will resubmit the IPOC for re-review within seven (7) calendar days from receipt of request by the MCO.

a. The PCS agency must:

1. 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;

2. 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;

3. 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;

4. Submit the IPoC to the MCO for review if the IPoC varies from the PCS Allocation Tool; Provide the consumer with a copy of their approved IPoC;

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

6. 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

7. 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.

L. 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 an 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:

a. 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:

1. The consumer’s name and social security number;
2. How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
3. 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
4. Where the consumer will be housed after the medical procedure.

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

c. 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.

1. 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:

2. The HSD-approved LOC criteria; and

3. The CNA.

M. PCS Agency Transfer Process: A consumer requesting to transfer services from one PCS agency to another Medicaid approved PCS agency may request a transfer form (MAD 062 or other approved transfer/closure form) from his/her MCO. Transfers may only be initiated by the consumer, his/her legal representative, or by a PCS agency on behalf of a consumer or his/her legal representative. Transfer requests shall not be requested by the personal care attendant. Transfer approvals are determined by the MCO and should be initiated by the consumer through the consumer’s assigned care coordinator.

The following outlines the process for PCS Agency Transfers:

a. The consumer must inform his/her MCO of the desire to transfer to another PCS agency;

b. The consumer must complete a MAD 062 or an approved transfer form to include: the consumer’s signature; the date of the signature of the receiving PCS agency; and the justification for the transfer.

c. The MCO will process the transfer request within 15 business days after receipt of the transfer request.

d. If approved, the MCO works with both the agency from which the consumer is currently receiving services (originating agency) and the agency to which the consumer would like to transfer (receiving agency) to complete the transfer.
e. Originating agencies are responsible for continued provision of services until the transfer is complete.

f. Upon approval of the request, the MCO will issue a new prior authorization to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer. The prior authorization will include: a new prior authorization number and new dates of service and units remaining for the remainder of the IPOC year.

g. The MCO will notify the consumer as well as the receiving PCS agency and issue an ending authorization to the originating agency.

The following outlines the MCO review process for PCS Agency Transfers:

a. When the MCO receives a request for a transfer from a consumer or PCS agency on behalf of a consumer or his/her legal representative, the consumer’s Care Coordinator will interview the consumer to determine if the request is **consumer-driven**.

b. The Care Coordinator will ask the consumer or his/her legal guardian for specific reasons for the transfer, including but not limited to: Will you be taking your caregiver with you? If the consumer is taking his/her caregiver, the Care Coordinator should ask why the consumer is requesting a transfer.

c. The Care Coordinator will contact the originating and the receiving agency to investigate the reasons given by the consumer and/or legal representative. In addition, the Care Coordinator will ensure the consumer has notified both agencies.

d. If, during the review process, the MCO determines that the originating and/or receiving agency is not compliant with the applicable Medicaid regulations, the MCO shall conduct an audit of the agency and if necessary provide additional training or impose a corrective action plan. For example, if the receiving agency has engaged in solicitation, or if the originating agency is not sending back-up caregivers or the caregivers are not showing up on the scheduled days or for the hours care is planned for, these issues need to be addressed by the MCO and corrected by the agencies.

e. If, during the course of the review process, the Care Coordinator finds that the consumer has requested three (3) transfers within a six month period, the Care Coordinator shall meet with the consumer and/or legal guardian to try to determine the reason for such requests and consider whether to approve or deny the transfer.

f. The consumer and/or legal guardian will not be allowed to hire an individual to be his/her attendant who has not passed a nationwide criminal history screening or an attendant that has been terminated from another agency for fraudulent activities or other misconduct. The Care Coordinator will educate the consumer about the Medicaid PCS policies.
g. When reviewing a transfer request, the MCO should take into consideration whether the consumer can speak and read English. If the consumer does not speak or read English, the MCO shall provide a translator to ensure that the consumer’s options have been explained and that the consumer fully understands his/her options, and that the service model selected is available to the consumer.

h. The Care Coordinator should ensure that the location of the agency or provider is convenient to the consumer.

i. A consumer who does not agree with the MCO’s decision shall utilize the MCO grievance and appeal process.

j. 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.

k. The originating agency is responsible for the continuance of PCS while the hearing is pending, if continuation of benefits is requested timely by the consumer and approved by the MCO.

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.

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

l. The consumer is requesting more hours/services;

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

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

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

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

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

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

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

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

N. Consumer Closure: The transfer/closure form may also be used by a consumer or PCS agency to initiate closure of PCS for a member who has gone 90 consecutive days or more without PCS. The PCS agency will submit the transfer/closure form
to the MCO and the MCO will call and verify with the consumer that PCS are no longer needed or wanted. After verification is received the MCO will provide an end authorization to the PCS agency.

O. Consumer Discharge: A consumer may be discharged from a PCS agency.

P. 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.

   a. A justifiable reason for discharge may include:

      1. Staffing problems (i.e., excessive request for change in attendants, such as three or more during within 30 calendar days);

      2. 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;

      3. 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;

      4. Illegal use of narcotics or alcohol abuse;

      5. Fraudulent submission of timesheets; or

      6. 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.

b. 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 discharge process, cooperate with the MCO, and continue services throughout the discharge. 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.
c. 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.

a. 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:

b. 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;

c. 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;

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

e. Illegal use of narcotics, or alcohol abuse;

f. Fraudulent submission of timesheets; or

g. Unsafe or unhealthy living conditions or environment.

h. 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 MCO billing instructions. Reimbursement for PCS will be based on the negotiated rate with the MCO.

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:
   a. Contacting a consumer who is receiving services through another PCS or any another Medicaid program;
   b. Contacting a potential consumer to discuss the benefits of its agency, including door to door, telephone, mail and email solicitation;
   c. Offering a consumer/attendant a finder fee, higher wage, 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;
   d. 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;
   e. Making false promises;
   f. Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
   g. Misrepresenting itself as having affiliation with another entity; and
   h. 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 not be provided at the same time. The Private Duty Nursing service offered through the Community Benefit Service program will vary in scope and duration from Medicare and Medicaid skilled nursing. Private Duty Nursing services will be offered to members who are 21 years of age and older receiving the Community Benefit Service as the provider of last resort in accordance with the State Medicaid Plan, State Medicaid Manual, Part 4, Section 4310 and Section 4442.1. A copy of the written referral will be maintained in the member’s file by the private duty nursing provider and shared with the MCO. Children (individuals under the age of 21) receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). 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.
L. 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:
a. The task to be performed,
b. How frequently the task is to be performed,
c. The duration that the order is applicable,
d. 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.
   a. A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is considered a qualified private duty nurse when the following criteria are met.
   b. Must have current licensure as required by the state of New Mexico.
   c. 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.
   d. Nursing services must be furnished through a licensed Home Health Agency, licensed Rural Health Clinic or certified federally Qualified Health Center.
   e. 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.

f. 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.

g. 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

a. 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.

b. 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.

c. 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:
a. Face-to-face activities that are described above in the Scope of Service for Private Duty Nursing.
b. Attendance and/or telephone conference call to participant in interdisciplinary team meetings.
c. Development of the plan of care/treatment, not to exceed four (4) hours annually.
d. Reimbursement is on a unit rate per hour and rounded to the nearest quarter.
e. 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:
   a. Performing specific errands for the individual and/or family that are not program specific.
   b. Friendly visiting.
   c. Financial brokerage services, handling of member finances, or preparation of legal documents.
   d. Time spent on paperwork or travel that is administrative for the provider.
   e. Transportation of members.
   f. Pick up and/or delivery of commodities.
   g. Other non-Medicaid reimbursable activities.

E. Private duty nursing 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. 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, to reduce stress and provide temporary relief to meet a family crisis, emergency or caregiver’s illness as determined in the Comprehensive Care Plan (CCP). A primary caregiver is the individual who has been identified in the CCP and who assists the member on a frequent basis, i.e. daily or at a minimum, weekly. Respite provides a temporary relief to the primary caregiver during times when he/she would normally provide unpaid care. If a caregiver needs a break during the time when he/she provides paid care, the agency must provide a substitute caregiver. Respite services may be provided in the member’s home, in the respite provider’s home and in the community. Respite services are limited to a maximum of 100 hours per CCP year. Respite services must not be provided by a member of the member’s household or by any relative approved as the paid caregiver. Respite services are provided pursuant to the CCP, developed and authorized by the recipient of service and the 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 CCP:
      a. Sweeping, mopping or vacuuming of carpets, hardwood floors, or linoleum;
      b. Dusting of furniture;
      c. Changing of linens;
      d. Doing laundry (member’s clothing and linens only);
      e. Cleaning bathrooms (tub and/or shower area, sink, and toilet); and/or
      f. 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 CCP 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 CCP may include the following tasks to be performed by the respite service:
a. Bathing – Giving a Sponge bath/Bed bath/Tub Bath/Shower, including transfer in/out;
b. Dressing – Putting on, fastening, removing clothing; including prosthesis;
c. 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;
d. 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;
e. 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;
f. Perineal Care – Cleansing of the perineal area and changing of sanitary napkins;
g. Toileting – Transferring on/off toilet, bedside commode and/or bedpan; cleaning perineal area, changing adult briefs/pads, readjusting clothing;
h. 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);
i. 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).
j. Mobility Assistance – Assistance in ambulation, transfer and toileting, Defined as follows:
k. 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;
1. Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or
m. Toileting – Transferring on or off toilet.

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

B. Administrative Requirements:
a. 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.
b. Respite services may be provided by agencies approved by HSD/MAD.
c. 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.
d. 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.
e. Respite agencies must comply with all requirements set forth in the Medicaid Provider Participation Agreement (PPA).
f. 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.
g. Respite agencies must have available in the member’s home a current copy of the CCP and any additional materials/instructions related to the member’s care.
h. 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.
i. Respite supervisors must provide specific instructions to assigned respite staff on each member prior to providing services to the member.
j. 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 (PPA). 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 CCP 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.

5. AUTHORIZATION OF RESPITE SERVICES
   a. Scheduling of hours for use of Respite Services will be the responsibility of the member 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 unless additional hours are approved by the MCO per Care Plan year.

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 perceptional 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:
      a. Obtaining pertinent medical history.
      b. Assessing of the member for specific needs in gross/fine motor skills pertinent to occupational therapy.
      c. Adapting the member’s environment in order to meet his/her needs.
      d. Evaluating, administrating and interpreting tests.
      e. 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.
      f. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
      g. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
         1. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings. Identify short-and long-term goals that are measurable, objective, and related to functional mobility as determined by medical history and evaluative findings.
         2. 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.

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

4. Implement and administer appropriate treatment.

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

i. 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

a. Graduation from an accredited occupational therapy program and current licensure as required by New Mexico State law.

b. Must have a current licensure by state of New Mexico.

c. Occupational therapy experience preferably in home care and general acute care.

d. Must have access to all required diagnostic and therapeutic materials to provide services.

e. 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.

f. 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.

g. 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
   a. 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.
   b. Provider agencies will establish and maintain financial reporting and accounting for each individual.
   c. 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.
   d. 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:
      a. Face-to-face activities described in the Scope of Service.
      b. Maximum of eight (8) hours for an initial comprehensive individual assessment.
      c. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
         1. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
         2. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
         3. Annual maximum of eight (8) hours to arrange assistive technology development.
         4. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
         5. 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:
   a. Performing specific errands for the individual and/or family that are not program specific.
   b. Friendly visiting.
   c. Financial brokerage services, handling of member finances, or, preparation of legal documents.
   d. Time spent on paperwork or travel that is administrative for the provider.
   e. Transportation of members.
   f. Pick up and/or delivery of commodities.
   g. 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 on 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:
   a. Obtaining pertinent medical history.
   b. Assessing of the member on physical strengths and deficits including, but limited to:
      1. Range of motion for all joints.
      3. Skin integrity and respiratory status.
   c. Functional level of motor developmental level.
   d. Adapting the member’s environment in order to meet his/her needs.
   e. Evaluating, including the administration and interpreting tests and measurements within the scope of the practitioner;
   f. 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.
   g. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
   h. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
   i. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
   j. 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.
k. Review physician’s request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
l. Implement and administer appropriate treatment.
m. Providing the member or caregiver education and documenting in the member’s medical record.
n. 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.

a. 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.

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
      a. Graduation from an accredited physical therapy program and current licensure as required by New Mexico State law.
         i. Must have a current licensure by state of New Mexico.
         ii. Physical therapy experience preferably in home care and general acute care.
         iii. Must have access to all required diagnostic and therapeutic materials to provide services.
         iv. 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.
         v. 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.
         vi. 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
   a. 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.
   b. 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.
   c. 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
   a. to complete progress reports and/or to revise annual plan.
   b. Annual maximum of eight (8) hours to arrange assistive technology
development.
      1. Reimbursement is on a unit rate per hour and rounded to the
         nearest quarter hour.
      2. Training on member specific issues is reimbursable, general
         training requirements are an administrative cost and not billable.

C. 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:
      a. Performing specific errands for the individual and/or family that are not
         program specific.
      b. Friendly visiting.

D. Financial brokerage services, handling of member finances, or, preparation of
   legal documents. Therapy services must abide by all federal, state, HSD policies
   and procedures regarding billable and non-billable items.

E. Billable hours are as follows:
   a. Face-to-face activities described in the Scope of Service.
   b. Maximum of eight (8) hours for an initial comprehensive individual
      assessment.
   c. Maximum of eight (8) hours to develop an initial comprehensive therapy
      plan.
d. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
e. Annual maximum of six (6) hours
f. Time spent on paperwork or travel that is administrative for the provider.
g. Transportation of members.
h. Pick up and/or delivery of commodities.
i. Other non-Medicaid reimbursable activities.

F. 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.

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

H. 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:
   a. Obtaining pertinent medical history.
   b. Assessing for speech-language disorders.
   c. Assessing for swallowing disorders (dysphasia).
   d. 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).
   e. Assessing of oral motor function.
   g. Assessing of resonance and nasal airflow.
   h. Assessing of orofacial myofunctional patterns.
   i. 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.
   j. Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response.
   k. Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation.
   l. Analyze and interpret member’s needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings.
   m. 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.
   n. 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.
   o. Review physician’s request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings.
p. Implement and administer appropriate treatment.
q. Providing the member or caregiver education and documenting in the member’s medical record.
r. 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.
s. The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services.
t. 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
      a. 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).
      b. Must have a current licensure by state of New Mexico.
      c. Speech-language therapy experience preferably in home care and general acute care.
      d. Must have access to all required diagnostic and therapeutic materials to provide services.
      e. 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.
      f. 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
      a. 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.
      b. Provider agencies will establish and maintain financial reporting and accounting for each individual.
c. 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.
d. 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:
   a. Face-to-face activities described in the Scope of Service.
   b. Maximum of eight (8) hours for an initial comprehensive individual assessment.
   c. Maximum of eight (8) hours to develop an initial comprehensive therapy plan.
   d. Attendance and/or telephone conference call to participate in interdisciplinary team meetings.
   e. Annual maximum of six (6) hours to complete progress reports and/or to revise annual plan.
   f. Annual maximum of eight (8) hours to arrange assistive technology development.
   g. Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour.
   h. 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:
   a. Performing specific errands for the individual and/or family that are not program specific.
   b. Friendly visiting.
   c. Financial brokerage services, handling of member finances, or, preparation of legal documents.
   d. Time spent on paperwork or travel that is administrative for the provider.
e. Transportation of members.
f. Pick up and/or delivery of commodities.
g. 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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<td>Home Health Aide</td>
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<td>Hour</td>
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<tr>
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<tr>
<td>Personal Care-Directed training</td>
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<td>1 unit + 1 month</td>
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<td>T1003</td>
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<tr>
<td>Respite RN</td>
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9 SELF-DIRECTED COMMUNITY BENEFIT (SDCB)

Revision dates: August 15, 2014; February 23, 2015; March 1, 2016, March 1, 2017

Effective date: January 1, 2014

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 covered services and supports.

SDCB provides self-directed Home and Community-Based Services (HCBS) to eligible members who are living with conditions associated with aging, disabilities, certain traumatic or acquired brain injuries (BI), acquired immunodeficiency syndrome (AIDS).

Home and Community-Based Services shall meet the following standards:
A. Are integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS;
B. Are selected by the individual from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the individual’s needs and preferences;
C. Ensure an individual’s rights of privacy, dignity and respect, and freedom from coercion and restraint;
D. Optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
E. Facilitate individual choice regarding services and supports, and who provides them.

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.

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 covered services they need, as identified in the most recent Comprehensive Needs Assessment (CNA). SDCB members also decide when, where and how those SDCB covered services will be provided and who they want to provide them. SDCB members decide who they want to assist them with planning and managing their SDCB covered services within a managed care environment. Self-Direction means that SDCB members have more choice, control, flexibility, freedom and responsibility in directing their community benefits.

**DEFINITIONS AND ACRONYMS**

1. **Authorized Agent (AA):** The member may choose to appoint an authorized agent 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 agent by signing a release of information form indicating the member’s consent to the release of confidential information. The authorized agent 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 agent does not require a legal relationship with the member. While the member’s authorized agent can be a service provider for the member, the authorized agent cannot serve as the member’s care coordinator/support broker. If the authorized agent is an employee, he/she cannot sign his/her own timesheet.

2. **Authorized Representative (AR):** Authorized representative is an individual designated to represent and act on the member’s behalf. The member or authorized representative must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An authorized representative may be an attorney representing a person or household, a person acting under the authority of a valid power of attorney, a guardian, or any other individual or individuals designated in writing by the eligible recipient or member.

3. **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.

4. **Employer of Record (EOR):** Individual responsible for directing the work of SDCB employees by recruiting, hiring, training, supervising and terminating employees, and ensuring payment to employees and vendors.

5. **Financial Management Agency (FMA):** Contracted with each Centennial Care MCO and helps the SDCB member implement the approved SDCB Care Plan by receiving and processing payment requests for the SDCB member’s employees and vendors, tracking the SDCB expenditures and credentialing the SDCB employees and vendors.

6. **FOCoSonline:** The web-based system used by the SDCB FMA for receiving and processing SDCB payment requests. The FOCoSonline system is also used by SDCB members, care coordinators, and support brokers to develop and submit SDCB care plan/budget requests for MCO/UR review, and to monitor utilization and spending throughout the SDCB care plan year.

7. **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).

8. **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.

9. **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 services or related goods requested in the SDCB care plan/budget.

10. **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.

11. **Reconsideration:** SDCB members who disagree with an adverse 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 adverse decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.

12. **Self-Directed Community Benefit (SDCB):** Is a component of the State’s 1115 (c) Medicaid Managed Care waiver which allows eligible members the option to access SDCB Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, member protections, and quality assurance and quality improvement. SDCB members have choices (among the state-determined SDCB services and related goods) in identifying, accessing and managing the services and related goods needed to meet their personal goals.

13. **SDCB Budget:** The maximum budget allotment available to an eligible SDCB member, determined by his/her established nursing facility level-of-care (NF-LOC), comprehensive needs assessment (CNA), and the amount and type of services the member was receiving in the ABCB. 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.

14. **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 related goods; the type of provider who will furnish each service or related good; other services and related goods to be used by 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 is mandatory for all SDCB members and must be processed through the FOCoSonline system.
15. **SDCB Member:** An individual who meets the medical and financial eligibility and is approved to receive services through the SDCB after having receiving ABCB for a minimum of 120 calendar days.

16. **Support Broker (SB):** An individual who provides support to SDCB members and assists 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 by a MCO.

**SDCB MEMBER RIGHTS**

A SDCB member has the right to:

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

**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 and policies can result in an involuntary termination from the SDCB.

The most basic responsibility of each SDCB member is to maintain his/her financial and medical eligibility to remain in the SDCB. This includes completing the required documentation to determine initial and annual financial eligibility and participating in the initial and annual comprehensive needs assessment (CNA) conducted by the Managed Care Organization (MCO). The care coordinator and support broker may assist with the application and recertification process as needed.

1. **Ongoing SDCB Member Responsibilities:**
   A. Comply with the rules and policies that govern the SDCB;
   B. 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;

C. 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;

D. Use SDCB funds appropriately by only requesting services and related goods covered by the SDCB and only purchasing services and related goods after they have been approved by the MCO/UR;

E. Comply with the approved SDCB care plan and not spend more than the authorized budget;

F. Work with the care coordinator by attending scheduled meetings and assessments, in the member’s home as required, and providing documentation as requested;

G. Respond to requests for additional documentation and information from the care coordinator, support broker, Fiscal Management Agency (FMA), and the MCO/UR within the required deadlines;

H. Report to the local Income Support Division (ISD) office, within 10 business days, any change in circumstances, including, but not limited to, a change in address or hospitalization, which may affect eligibility for the program. Changes in address or other contact information must also be reported to the care coordinator, support broker and the FMA within 10 calendar days;

I. Report to the care coordinator and support broker if hospitalized for more than three (3) consecutive nights so that a new appropriate LOC can be obtained; and

J. Communicate with SDCB service providers, State contractors and State personnel in a respectful, non-abusive and non-threatening manner.

2. Member/Employer of Record (EOR) Responsibilities: Every SDCB member must have an Employer of Record (EOR) who is responsible for directing the work of SDCB employees, and ensuring accurate and timely employee and vendor payment requests are sent to the FMA for processing. 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. If a SDCB member’s Power of Attorney includes the authority to make decisions regarding financial matters, the POA must be the member’s EOR due to the financial responsibilities inherent in the SDCB program. A designated EOR may not be an employee of the member. 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 and policies. The care coordinator conducts an EOR Self-Assessment with the SDCB member to determine if the member will require assistance in fulfilling the EOR responsibilities. If the EOR Self-Assessment demonstrates that the member is not able to be his/her own EOR, and the member does not designate a qualified individual to serve as the EOR, the member shall not be allowed to transfer to SDCB until the member designates a suitable EOR.
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 SDCB budget amounts spent on paying employees and for approved services and related goods. EORs authorize the payment of timesheets and invoices by the Financial Management Agency (FMA). An EOR cannot be paid for any services utilized by the SDCB member for whom he or she is the EOR and the EOR cannot be paid for performing the EOR functions.

The SDCB member/EOR responsibilities include:

A. Arranging for the delivery of SDCB services, supports and related goods as approved in the SDCB care plan;
B. Verifying and attesting that employees meet the minimum qualifications for employment as required by the SDCB;
C. Orienting, training, and directing SDCB employees in providing the services that are described and authorized in the member’s SDCB care plan;
D. 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;
E. Submitting all necessary and 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 timely and accurate payment to SDCB providers;
F. Agreeing that SDCB 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;
G. Agreeing to select or employ the employee on an interim (temporary) basis until a final criminal background check (CBC) has been successfully completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3. The EOR discusses this with the employee and reserves the right to dismiss the employee based on the results of the CBC;
H. Providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;
I. Review and approve/deny completed employee timesheets in order to pay employees according to the FMA predetermined payroll schedule. Net wages are 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;
J. Reporting any incidents of abuse, neglect or exploitation by any employee or
other service provider to the support broker and/or care coordinator;
K. Maintaining SDCB employee and service records and documentation in accordance with SDCB rules and policies, and federal and state employment rules;
L. Fully cooperating with the NM Department of Workforce Solutions (DWS) in any investigations or other matters related to his/her SDCB employees;
M. Fully cooperating with the State’s worker’s compensation carrier, currently NM Mutual. Responsibilities include reporting claims and providing information to NM Mutual;
N. Meeting federal employer requirements, such as completing and maintaining a federal I-9 form for each employee as required by law; and
O. When necessary, requesting assistance from the support broker and/or care coordinator with any of these SDCB responsibilities.

SDCB SUPPORTS

In the SDCB, important resources of support and direction for SDCB members are the MCO, the Support Broker 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 care plan. The Support Broker provides support to the SDCB member (or the member’s family/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. The FMA acts as the intermediary between the SDCB member and the Medicaid payment system and assists the SDCB member or the EOR with employer-related responsibilities.

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

2. Care Coordinator
   The care coordinator (CC) is responsible for managing the member’s acute care, behavioral health care, long-term care, and home and community based services. In SDCB, the care coordinator is primarily responsible for coordinating all aspects of the SDCB member’s care and for determining the SDCB budget, and submitting the SDCB care plan to the MCO/UR for review and approval/denial. SDCB CC related assistance includes, but is not limited to:
A. Understanding SDCB member and EOR roles and responsibilities;
B. Identifying resources outside the SDCB, including natural and informal supports, that may assist in meeting the SDCB member’s needs;
C. Understanding the array of SDCB covered services, supports, and related goods;
D. Determining and assigning the annual budget for the SDCB member, based on the CNA, to address the home and community based needs of the SDCB member in accordance with the requirements stated in the managed care contract and the member’s Community Benefit;
E. Providing the support broker with the current and all historical Comprehensive Needs Assessments (CNA) including the Assessor’s individual specific health and safety recommendations, and the calculations used to determine the SDCB budget;
F. Monitoring utilization of SDCB services and related goods on a regular basis;
G. Conducting employer-related activities such as completing the EOR self-assessment with the member and informing the FMA of the designated EOR;
H. Identifying and resolving issues related to the implementation of the SDCB care plan/budget;
I. 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;
J. Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;
K. Monitoring quality of services provided by support brokers; and
L. Working with the member to provide the necessary assistance for successful SDCB implementation.

3. Support Broker

Support broker services are direct services intended to educate, guide, and assist the SDCB member to make informed planning decisions about SDCB services and supports and to assist the SDCB member with quality assurance related to the SDCB care plan. This leads to the development of a SDCB care plan that is based on the SDCB member’s assessed needs and is in accordance with 8.308.12 NMAC, and the Medical Assistance Division Managed Care Policy Manual.

Support broker services help the SDCB member to identify supports, services and related goods that meet his/her need for SDCB needs identified in the most recent CNA and are specific to the member’s disability or qualifying condition and help prevent institutionalization. Support broker services provide a level of support to SDCB members that are unique to their individual needs in order to maximize their ability to self-direct in the SDCB.

A. The extent of assistance is based upon the individual SDCB member’s 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 SDCB care plan revisions;
d. Assist with EOR functions including, but not limited to recruiting, hiring and supervising SDCB providers;
e. Assist with developing job descriptions for the SDCB direct support caregivers;
f. Assist with completing forms related to SDCB employees;
g. Assist with approving timesheets and purchase orders or invoices for related goods, obtaining quotes for services and related 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 SDCB providers for services rendered;
j. Develop the SDCB care plan based on the SDCB budget amount determined by the annual CNA; and
k. Assist in completing all documentation required by the FMA.

B. Support broker services begin with the enrollment of the member in SDCB and continue throughout the SDCB member’s participation in SDCB. The support broker shall:

a. Conduct a transition meeting, including the transfer of program information prior to the SDCB enrollment meeting, for those members transitioning from the Agency Based Community Benefit (ABCBB);
b. Assist SDCB members to transition from/to ABCB/SDCB.
c. Provide the SDCB member with information, support and assistance during the annual Medicaid eligibility processes, including the annual CNA and the annual medical/financial eligibility processes;
d. Assist existing SDCB members with annual LOC requirements within ninety (90) calendar days prior to the expiration of the LOC;
e. 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. Ensure the member has received and reviewed the SDCB Rules and Managed Care Policy Manual and provide responses to their questions and/or concerns;
   ii. General overview of the SDCB including key agencies, their
responsibilities and contact information;

iii. Discuss the annual Medicaid eligibility requirements and offer assistance in completing these requirements as needed;

iv. Discuss and review SDCB member roles and responsibilities;

v. Discuss and review the EOR roles and responsibilities;

vi. Discuss and review the processes for hiring SDCB employees and contractors and required paperwork;

vii. Discuss and review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees;

viii. Discuss and review the background check and other credentialing requirements for SDCB employees and vendors; and

ix. Referral for accessing training for the FOCoSonline system; and to obtain information on the Financial Management Agency (FMA).

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

g. Provide information on the SDCB care plan including covered services and related goods, planning tool and community resources available;

h. Assist the SDCB members in utilizing all program assessments including CNA, to develop each SDCB care plan;

i. Educate members regarding SDCB covered services, supports and related goods;

j. Assist SDCB member to identify resources outside SDCB that may assist in meeting his/her needs as identified in the CNA.

k. Assist the SDCB member with the application for LRI as employee process; submit the application to the MCO/UR;

l. Assist SDCB members with the Environmental Modification process;

m. Serve as an advocate for the SDCB member, as needed, to enhance his/her opportunity to be successful in the SDCB;

n. Assist the SDCB member with reconsiderations of services or related goods denied by the MCO/UR, submit documentations as required, and participate in MCO appeals process and State Fair Hearings as requested by the MCO, SDCB member or state;

o. Assist the SDCB member with the quality assurance activities to ensure implementation of the member’s SDCB care plan, and utilization of the SDCB annual budget;

p. Assist SDCB members to transition to another support broker agency when requested. Support Broker transitions should occur within 30 calendar days of SDCB member’s written request, but may occur sooner based on the needs of the SDCB member. Transition from one support broker agency to another can only occur at the first of the month. Support broker agency transitions may not occur if there are less than 120 days remaining in the current LOC; and
q. Assist SDCB members to identify and resolve issues related to the implementation of the SDCB care plan.

C. Support Brokers must ensure that the SDCB care plan for each member is submitted in the appropriate format as prescribed by the state, by using the FOCoSonline system.

a. The SDCB care plan in FOCoSonline shall include the following:
   i. The requested services and supports that are covered by the SDCB, and necessary to address the needs of the member as determined through the CNA and person-centered planning process;
   ii. The purpose for the requested services, expected outcomes, and methods for monitoring progress must be clearly and specifically identified and addressed;
   iii. Clear, specific and accurate calculation of the employee/vendor reimbursement rate including all local and/or federal taxes using the calculator in FOCoSonline; and
   iv. The quality indicators, identified by the member, for the services and supports provided through the SDCB. SDCB care plan revisions shall be completed and submitted as needed, in the format as prescribed by the state. No more than one (1) revision is allowed to be submitted at any given time. The annual SDCB care plan must be submitted to the care coordinator and MCO/UR at least 30 calendar days prior to the expiration of the current SDCB plan so that sufficient time is afforded for MCO/UR review. A copy of the final approved SDCB care plan and budget documents must be provided to each SDCB member.

D. 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 once per quarter. It is mandatory that a minimum of one visit per SDCB care plan year is to 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 related goods.

The quarterly visits are for the following purposes:
   a. Review and document progress on implementation of the SDCB care plan;
   b. Review and document any usage and the effectiveness of the 24-hour backup plan and update the backup plan as necessary;
   c. Review SDCB care plan and budget spending patterns (over and underutilization);
   d. Review and document the SDCB member’s access to SDCB related goods
requested and approved in the SDCB care plan;
e. Review any incidents or events that have impacted the SDCB member’s health and welfare or ability to fully access and utilize service(s) as identified and approved in the SDCB care plan; and
f. Identify other concerns or challenges as noted by the member/representative/EOR.

E. Administrative Requirements

Support broker services may be provided by direct MCO personnel or by Support Broker Agencies subcontracted by the MCO. SDCB members may choose to work with any MCO-approved support broker agency in their region. If an MCO employs MCO personnel to provide support broker services, the same qualifications and criteria that are used for Support Broker Agencies also applies to the MCO personnel.

The support broker agency shall comply with all applicable federal, state rules, all policies and procedures governing support broker services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:

b. Have a current business license issued by the state, county, or city government as required;
c. Maintain financial solvency;
d. 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 rules, policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, CNA, person-centered planning and SDCB care plan development, and adhere to all other training requirements as specified by the state;
e. Ensure that all employees are trained and competent in the use of the FMA and FOCoSonline system;
f. 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

g. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.
h. The support broker agency shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous quality improvement.

The support broker agency shall ensure that SDCB members have access to their support broker. This requirement includes, but is not limited to the following:
a. The support broker agency must maintain a presence in each region for which they are providing services;

b. The support broker agency must maintain a consistent way (for example, phone, pager, email, and fax) for the SDCB 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 agency must maintain a consistent way (for example phone, pager, email, and fax) for the SDCB 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 agency must provide a location to conduct confidential meetings with SDCB members when it is not possible to do so in the SDCB member’s home. This location must be convenient for the SDCB member and compliant with the Americans with Disabilities Act (ADA);

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

f. The support broker agency must maintain an operational email address, internet access, and the necessary technology to access SDCB related systems;

h. The support broker agency shall maintain a current local/state community resource manual.

i. The support broker agency shall adhere to Medicaid General Provider policies 8.302.1.

j. The support broker agency shall ensure the development and implementation of a written grievance procedure in compliance with 8.349.2.11 NMAC.

k. The support broker agency shall meet all of the qualifications set forth in 8.304.12 NMAC.

l. The support broker agency shall maintain HIPAA compliant primary records for each SDCB member including, but not limited to:
   i. Current and historical SDCB care plan and budget;
   ii. Contact log that documents all communication with the SDCB member;
   iii. Completed/signed quarterly visit form(s);
   iv. MCO/UR documentation of approvals/denials, including SDCB care plan and revision requests;
   v. MCO/UR correspondence; (requests for additional information, etc.);
   vi. Copy of current and all historical Comprehensive Needs Assessment (CNA) including the Assessor’s individual specific health and safety recommendations;
vii. Notifications of medical and financial eligibility;
viii. SDCB budget utilization reports from the FMA;
ix. Environmental Modification approvals/denials;
x. Responsible Individual (LRI) approvals/denials;
xi. Documentation of SDCB member and employee incident management training;
xii. Copy of legal guardianship or representative papers and other pertinent legal designations; and
xiii. Copy of the approval form for the authorized representative and/or authorized agent.

F. Support Broker Qualifications
Support broker agencies shall ensure that all individuals providing support broker services meet the criteria specified in this section.

a. Support broker providers shall:
i. Be at least 18 years of age;
ii. Possess a minimum of a Bachelor’s degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;
iii. Have one (1) year of supervised experience working with seniors and/or people living with disabilities;
iv. Complete all required SDCB orientation and training courses; and
v. 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

b. Support broker providers shall:
i. Be at least 18 years of age;
ii. 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;
iii. Be employed by an enrolled support broker agency or be employed by a Centennial Care MCO;
iv. Complete all required SDCB orientation and training courses; and
v. 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
The support broker agency may not provide any other direct services for SDCB members that have an approved SDCB care plan and are actively receiving services in the SDCB, and the support broker agency 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 agency.

H. Critical Incident Management Responsibilities and 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 MCO, Support Broker and/or Adult Protective Services (APS).

a. The support broker agency shall provide training to SDCB 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 SDCB member training shall also include reporting procedures for SDCB employees, members/member representatives, and other designated individuals. (Please refer to the Critical Incident Management Responsibilities for requirements).

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

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

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

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

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

a. Assure SDCB 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;

d. Provide all SDCB members with necessary documents, instructions and guidelines;
e. Collect all documentation necessary to verify that SDCB providers and vendors have the qualifications and credentials required by the SDCB rules;

f. 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;

g. Successfully complete criminal history and/or background investigations for prospective SDCB 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;

h. Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC Consolidated Online Registry (COR), to determine whether prospective SDCB service providers or employees of SDCB members are included in the registry. If a prospective SDCB provider or employee is listed in the Abuse Registry, that person or vendor may not be employed by a SDCB member/EOR;

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

j. Handle all payroll functions on behalf of 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;

k. Track and report on SDCB 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

l. 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 and/or support broker, and HSD/MAD, as appropriate.

B. 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 housing the SDCB care plan, noting the annual SDCB budget, 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 coordinators to develop and submit a SDCB care plan for MCO/UR review and approval/denial.
c. The MCO/UR also 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 related goods have been approved or denied.

d. The FMA will provide SDCB members, care coordinators and support brokers with training and access for FOCoSonline, as well as on-going technical assistance and help with problem solving.

PLANNING AND BUDGETING FOR SDCB COVERED SERVICES

1. 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/her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the SDCB care plan development 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 agency, each SDCB member shall receive a SDCB budget amount, which is determined by the care coordinator, based on the results of the NFLOC and the CNA. The SDCB budget amount is entered into FOCoSonline by the care coordinator. The SDCB member will receive 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 his/her abilities, to direct the 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 SDCB care plan development process. The SDCB care plan is entered into FOCoSonline by the support broker.

The SDCB care plan 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) as defined in the service description, 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, and rate of pay.

The SDCB care plan is developed by the SDCB member and the support broker. Once the SDCB care plan request is complete and approved by the SDCB member, the support broker notifies the care coordinator, via FOCoSonline, that the member’s SDCB care plan
is ready for review and submission into FOCoSonline. After reviewing the SDCB care plan, the care coordinator will submit it in FOCoSonline to the MCO/UR for review and approval or denial using FOCoSonline. Annual SDCB care plans shall be submitted by the care coordinator to the MCO/UR no later than 30 calendar days prior to the end of the current SDCB care plan/budget year. MCOs must provide the SDCB member with a written notice of action for all MCO/UR decisions made in response to SDCB service related requests made by the SDCB member via FOCoSonline.

2. SDCB Member’s Employer Authority
   The SDCB EOR is the common-law employer of all SDCB 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.

3. SDCB Member Decision-Making Authority
   SDCB members shall have authority to do the following:

   A. Complete the employer paperwork to be submitted to the FMA;
   B. Determine the amount paid for SDCB services within the State’s approved limits (Range of Rates, 9.A.);
   C. Schedule the provision of SDCB services;
   D. Specify service provider qualifications of the SDCB member’s choice, consistent with the qualifications specified in the SDCB rules and the Managed Care Policy Manual;
   E. Specify how SDCB services are provided, consistent with the SDCB rules and the Managed Care Policy Manual;
   F. Identify potential SDCB service providers and vendors and refer them to the FMA for enrollment;
   G. Arrange to have potential SDCB service providers paid for the approved SDCB services by ensuring that all proposed SDCB employees and service providers complete all FMA required paperwork, including a criminal background check when necessary. Payment for approved SDCB services and related goods cannot be made until all necessary and required paperwork is successfully completed and approved by the FMA;
   H. Review, approve and submit SDCB provider timesheets to the FMA within established timeframes. Timesheets may be submitted to the FMA by fax or through FOCoSonline. Failure to submit SDCB provider timesheets within the required timeframes will result in SDCB providers not being paid in accordance with the employee payroll schedule; and
   I. Review, approve and submit payment requests, according to the SDCB care plan, for approved SDCB services and related goods identified in the approved SDCB care plan. The SDCB member/EOR must submit to the FMA a Purchase Request Form (PRF) and an invoice or receipt from a SDCB vendor for any item he/she has an approved SDCB goal and budget to purchase.

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J. Additionally, the SDCB members:
   a. Cannot/will not be reimbursed directly for any SDCB services, supports and/or related goods;
   b. Must follow the SDCB care plan as approved by the MCO/UR;
   c. Shall work with the FMA to have all potential SDCB employees, providers and vendors approved and enrolled prior to delivery or provision of any SDCB service or good; and
   d. Shall be accountable for the use of all SDCB funds.

**SDCB QUALIFICATIONS FOR ALL SDCB EMPLOYEES, INDEPENDENT PROVIDERS, PROVIDER AGENCIES AND VENDORS**

In order to be approved as a SDCB employee, an independent provider, a provider agency (excluding support broker agencies, which are covered later in this document) or a vendor, each entity must meet the general and service specific qualifications found in the SDCB rules and Managed Care Policy Manual, and submit an employee agreement packet or vendor agreement packet, specific to the SDCB provider or vendor type, for approval to the FMA.

SDCB providers must meet all Federal and state requirements for home and community based providers.

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

1. General qualifications for SDCB individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies who are employed by a SDCB member/EOR to provide direct services:
   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 SDCB 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; 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;
G. meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 MAC); and
H. maintain documentation of services provided per the SDCB rules (8.308.12 MAC).

2. General qualifications for SDCB vendors, including those providing professional services:
   B. be qualified to provide the service;
   C. possess a valid business license, if applicable;
   D. 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;
   E. if a support broker provider, meet all of the qualifications set forth in 8.308.12 MAC;
   F. if a currently approved SDCB provider, be in good standing with the appropriate state agency;
   G. meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 MAC); and
   H. maintain documentation of services provided per the SDCB rules (8.308.12 MAC).

3. General qualifications for Legally Responsible Individuals (LRIs) who provide services:
   A. LRIs, e.g., the parent/guardian (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 the provision of SDCB covered services (except support broker) 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).
   B. Extraordinary circumstances include the inability of the parent/legal guardian to find and retain other qualified, suitable caregivers when the parent/guardian would otherwise be absent from the home and, thus, the parent/guardian must stay at home to ensure the member’s health and safety. The member may request that the LRI (parent/guardian or spouse) be allowed to be employed by the SDCB member/EOR and provide SDCB services as approved in the member’s current SDCB care plan. The request must include documentation showing all attempts to employ other available resources in the member’s community, the challenges the member and/or providers encountered, and why the member-chosen providers were unable to successfully provide the approved SDCB covered service as approved in the SDCB care plan.
   C. 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. This includes, but is not limited to, transportation of minors to and from school, activities and events.

D. Requests to employ a LRI must be submitted in writing to the MCO. The request must be approved or denied in writing by the appropriate MCO/UR staff member. The approval of a LRI must be renewed annually, at the same time as the NFLOC and SDCB care plan.

E. Services provided by LRI’s must:
   a. Meet the definition of a SDCB covered service and be specified in the member’s approved SDCB care plan;
   b. Be provided by a SDCB member’s parent/guardian or spouse who meets the provider qualifications and training standards specified in the SDCB rules and these service descriptions and qualifications for that covered SDCB service; and
   c. Be paid at a rate that does not exceed the SDCB Range of Rates (9.A) for the specific service the LRI is approved to provide, and be approved by the MCO/UR.

SDCB COVERED SERVICES

1. All SDCB services are subject to the approval of the MCO/UR. Below is a list of SDCB covered services and related goods for members in SDCB, followed by a detailed service description:
   - Behavior Support Consultation Services
   - Customized Community Support
   - Emergency Response
   - Employment Supports
   - Environmental Modifications
   - Home Health Aide
   - Homemaker/Direct Support
   - Nutritional Counseling
   - Private Duty Nursing
   - Related Goods
   - Respite
   - Skilled Therapy Services for Adults
   - Specialized Therapies
   - Transportation (Non-Medical)

2. Descriptions for each of the above SDCB covered services.
   A. BEHAVIOR SUPPORT CONSULTATION SERVICES
      a. Definition of Service
         Behavior Support Consultation services consist of functional support
assessments, treatment plan development and training and support coordination for a SDCB member related to behaviors that compromise a member’s quality of life. Behavior Support Consultation services are provided in an integrated/natural setting or in a clinical setting.

b. Scope of Services
   i. Inform and guide the SDCB member, family, employees and/or vendors toward understanding the contributing factors to the SDCB member’s behavior;
   ii. 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;
   iii. Support effective implementation based on a functional assessment and subsequent SDCB care plans;
   iv. Collaborate with medical and ancillary therapies to promote coherent psychotherapeutic medications; and
   v. Monitor and adapt support strategies based on the response of the SDCB member and his/her family, employees and/or vendors.

c. Behavior Support Consultant Qualifications – Individual:
   i. Provide a tax identification number;
   ii. 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).
   iii. 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/RNSC);
      8. Licensed marriage and family therapist (LMFT); or
      9. Licensed practicing art therapist (LPAT).

d. Behavior Support Consultant Qualifications - Provider Agency:
   i. Provide a tax identification number; and current business license issued by state, county or city government, if required.
   ii. Maintain a member file within HIPAA guidelines to include:
      1. Member’s SDCB care plan;
      2. Reports as requested in the SDCB care plan;
iii. 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/RNSC);
   8. Licensed marriage and family therapist (LMFT); or
   9. Licensed practicing art therapist (LPAT).

B. CUSTOMIZED COMMUNITY SUPPORTS

   a. Definition of Service
   Customized Community Support Services are designed to offer the SDCB member flexible supports that are related to the member’s qualifying condition or disability. Customized Community Supports may include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized Community Supports may include adult day habilitation, adult day health and other day support models. Customized Community Supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.

   Customized Community Supports settings must be integrated and support full access of individuals receiving Centennial Care Community Benefits to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, with the same degree of access as individuals not receiving Medicaid HCBS.

   These services are provided at least four (4) or more hours per day one (1) or more days per week as specified in the member’s SDCB care plan. Customized Community Supports cannot duplicate any other SDCB service.

   b. Scope of Services
   Customized Community Support services include, but are not limited to the following:
   
   ii. Provide supports in congregate and community day programs that
assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills;

iii. Adult day health services;

iv. Adult day habilitation services; and

v. Other day support model services.

c. Customized Community Supports Qualifications - Provider Agency:

i. Possess a current business license, if applicable;

ii. Meet financial solvency;

iii. Adhere to training requirements;

iv. Maintain member records for each member within HIPAA compliance;

v. Develop and adhere to a records management policy;

vi. Develop and adhere to quality assurance rules and requirements; and

vii. Adult day health provider agencies must be licensed by NM DOH as an adult day care facility pursuant to 7.13.2 NMAC.

viii. Ensure all assigned staff meets the following qualifications:

1. Be at least 18 years of age;

2. Have at least one (1) 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/member representative;

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

a. Definition of Service

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

b. Scope of Services
   i. Testing and maintaining equipment;
   ii. Training SDCB members, caregivers and first responders on the use of the equipment;
   iii. 24 hour monitoring for alarms;
   iv. Checking systems monthly or more frequently if warranted (e.g. electrical outages, severe weather); and
   v. Reporting member’s condition that may affect service delivery.
   vi. Initial set-up and installation of ERS devices is not a covered service; see the service description for Environmental Modification for allowance of the initial set-up and installation.

c. Emergency Response Qualifications – Vendor/Agency:
   i. Comply with all laws, rules and regulations of the New Mexico State Corporation Commission for Telecommunications and Security Systems; and
   ii. Comply with all laws, rules and regulations from the Federal Trade Communication Commission (FCC) for telecommunications.

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

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

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.

b. Employment supports include the following services:

i. 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, budget 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.

ii. Job Development: Job development services are provided to SDCB 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 (5) components: job identification and development activities; employer negotiations; job restructuring; job sampling; and job placement.

c. Scope of Job Coach Services

Job coach services will include, but are not limited to the following:

i. Provide support to members as contained in the SDCB care plan as to achieve his/her outcomes;

ii. Teach vocational skills in a workplace setting;

iii. Employ job-coaching techniques and help SDCB members learn to accomplish job tasks to the employer’s specifications;

iv. Increase the member’s capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
v. 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;
vi. Identify specific information about the member’s employment interests, preferences and abilities;
vii. 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;
viii. Monitor and evaluate the effectiveness of the service and provide reports or documentation to the member as requested in the SDCB care plan;
ix. Address behavioral, medical or other significant needs identified in the SDCB care plan;
x. 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;
x. 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;
xii. Monitor the health and safety of the member;
xiii. Model behavior, instruct and monitor any work place requirements to the member;
xiv. Adhere to professionally acceptable business attire and appearance, and communicate professionally and in a respectful manner; and xv. Adherence to rules of the specific work place, including dress, confidentiality, safety rules and other areas required by the employer.
d. Scope of Job Development Services
   i. Identify potential employers and jobs in the area that provide work opportunities consistent with the member’s preferences, interests and choice;
   ii. Negotiate job functions, hours and supervision in the SDCB member’s best interest;
   iii. Conduct satisfaction surveys as requested by the SDCB member;
   iv. Broker relationships between the employer and the SDCB member in order to develop and maintain job success;
v. Identify potential employers and jobs in the area that provide work opportunities consistent with the SDCB member’s preferences, interests and choices;
vi. Conduct job task analysis to ensure appropriate job match(es);

vii. Assess barriers to SDCB member skill development on the job and provide or obtain appropriate accommodations tailored to the SDCB member’s ability to master task;

viii. Interact professionally in individual and group contacts, on the phone, in writing with various levels of the company, including human resources and management;

ix. 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;

x. Utilize, refer and communicate with the Division of Vocational Rehabilitation (DVR) concerning job placement and referral activities consistent with industry and SDCB standards;

xi. Utilize Department of Workforce Solutions (DWS) Navigators and One-Stop Career Centers, Business Leadership Network (BLN), Chamber of Commerce, Job Accommodation Network (JAN), Small Business Development Centers, Retired Executive, Businesses, community agencies, and the NM Employment Institute to achieve employment outcomes;

xii. Maintain on-going communication with various levels of the employer company to assure satisfaction to both the SDCB member and the company;

xiii. During the time of service delivery, ensure the SDCB member’s earnings and benefits are in accordance with Fair Labor Standards Act (FLSA). 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;

xiv. Conduct a vocational assessment or profile as deemed necessary upon request of the member;

xv. Provide a career development plan as deemed necessary or upon the request of the SDCB member;

xvi. 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;

xvii. Verify and ensure that SDCB 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

xviii. Provide career and skill development for advancement and integration in work-related activities or events.

e. Job Coach Qualifications – Individual Provider
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 SDCB member;
iv. Experience as a job coach for at least (1) one year;
v. Experience for at least (1) one year using job and task analyses;
vi. Trained on American with Disabilities Act (ADA);
vii. Trained on the purpose, function and general practices of the Division of Vocational Rehabilitation (DVR);
viii. 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;
ix. Complete training on critical incident, abuse, neglect, and exploitation reporting;
x. Complete SDCB member specific training; the evaluation of training needs is determined by the SDCB member or his/her legal representative; SDCB 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
xi. Meet any other service qualifications, as specified in the SDCB rules.

f. Job Developer Qualifications – Individual Provider
   i. Be at least 18 years of age;
   ii. Pass criminal background check and abuse registry screen;
   iii. Experience as a job developer for at least (1) one year;
   iv. Experience for at least (1) one year developing and using job task and analyses;
   v. 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;
   vi. 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

vii. 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;

viii. Complete training on critical incident, abuse, neglect, and exploitation reporting;

ix. 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

x. Meet any other service qualifications, as specified in the SDCB rules.

g. Job Coach and/or Job Developer Qualifications – Provider Agency
   i. Possess a current business license, if applicable;
   ii. Meet financial solvency;
   iii. Adhere to training requirements;
   iv. 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;
   v. Develop and adhere to a records management policy; and
   vi. Develop and adhere to quality assurance rules and requirements.

vii. 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:
i. Be at least 18 years of age;
ii. Experience as a job developer for at least (1) one year;
iii. Experience for at least (1) one year developing and using job task
and analyses;
iv. 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;
v. 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 (BLN);
4. Chamber of Commerce;
5. Job Accommodation Network (JAN);
6. Small Business Development Centers;
7. Retired Executives; and
8. New Mexico employment institute.

vi. 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 27-7

vii. a-1 et seq. and 8.11.6 NMAC;
viii. Complete training on critical incident, abuse, neglect, and
exploitation reporting;
ix. Complete SDCB member specific training; the evaluation of
training needs is determined by the SDCB member or his/her legal
representative; SDCB member is also responsible for providing
and arranging for provider training and supervising provider
performance; training expenses for paid SDCB providers cannot be
paid for with the SDCB member’s annual budget; and
x. Meet any other service qualifications, as specified in the SDCB
rules.

E. ENVIRONMENTAL MODIFICATION
a. Definition of Service

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

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

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

b. Scope of Services

Environmental Adaptations include the following:

i. Installation of ramps and grab-bars;
ii. Widening of doorways/hallways;
iii. Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
iv. Installation of lifts/elevators;
v. Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals and bidet adaptations and plumbing);
vi. Turnaround space adaptations;

vii. Installation of specialized accessibility/safety adaptations/additions;

viii. Installation of Trapeze and mobility tracks for home ceilings;
ix. Installation of Automatic door openers/doorbells;
x. Installation of Voice-activated, light-activated, motion- activated and electronic devices;
xi. Installation of Fire safety adaptations;
xii. Installation of Air filtering devices;
xiii. Installation of heating/cooling adaptations;
xiv. Installation of glass substitute for windows and doors;
xv. Installation of modified switches, outlets or environmental controls for home devices; and
xvi. Installation of alarm and alert systems, emergency response systems, and/or signaling devices.

c. Environmental Modification Qualifications – Individual Contractor and Agency Contractor
   i. Current business license;
   ii. Appropriate plumbing, electrician, contractor license; and/or
   iii. Appropriate technical certification or other license to perform the modification.

d. The Environmental Modification provider must:
   i. Provide a one (1)-year warranty from the completion date on all parts and labor;
   ii. Have a working knowledge of Environmental Modifications and be familiar with the needs of persons with functional limitations in relation to Environmental Modifications;
   iii. Provide consultation to family members, providers and MCOs concerning Environmental Modification projects to the SDCB member’s individual’s residence, and inspect the final Environmental Modification project prior to the member/EOR requesting the final payment to ensure that the adaptations meet the approved plan as submitted and approved for environmental adaptation; and
   iv. Provider must establish and maintain financial reporting and accounting for each member.

e. The Environmental Modification provider will submit the Environmental Modification Service Cost Quote Packet containing the following information and documentation to the MCO:
   i. Environmental Modification evaluation;
   ii. Service Cost Estimate. Drawings 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 SDCB member/EOR;
   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; and
vi. Documentation demonstrating compliance with the Americans with Disabilities Act (ADA).
f. The Environmental Modification provider must submit the following to the MCO, after the completion of work:
i. Letter of Approval of Work completed signed by the SDCB member/EOR;
ii. Photographs of the completed modifications.
g. The MCO must submit the following information to the provider:
i. Care Coordinator Individual Assessment of Need.
h. Reimbursement
Environmental Modification providers 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 (1) unit per Environmental Modification project. Reimbursement for Environmental Modification services will be based on the negotiated rate with the SDCB member/EOR.

Environmental Modification services are limited to five thousand dollars ($5,000.00) every five (5) years, beginning from the first date of service. Additional services may be requested if the member’s health and safety needs exceed the specified limit. The $5,000.00 – five (5) year time limit applies across all Community Benefit packages where Environmental Modifications are a covered service. *Example*: an Agency Based Community Benefit (ABCB) member receives an Environmental Modification of $2,300 leaving a $2,700 available balance for future Environmental Modification. Six (6) months later the ABCB member transitions to the Self-Directed Community Benefit (SDCB), the member now has $2,700 available for Environmental Modifications.

Environmental Modifications excludes 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 carpeting, fences, roof repair, storage sheds or other outbuildings, furnace replacement, insulation, and other general household repairs. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation related to the SDCB member’s medical condition.

**F. HOME HEALTH AIDE**
a. Definition of Service
Home Health Aide services provide total care or assist a SDCB member in all activities of daily living. Home Health Aide services assist the SDCB
member in a manner that will promote and improve the SDCB member’s quality of life and provide a safe environment for the SDCB member. Home health aide services can be provided outside the SDCB member’s home.

State plan Home Health Aide services are intermittent and are provided primarily on a short-term basis; whereas, in SDCB, Home Health Aide services are hourly services for members who need this service on a more long-term basis.

Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides do not administer medication(s), adjust oxygen levels, perform any intravenous procedures or perform sterile procedures. Home Health Aide services are not duplicative of homemaker/direct support services.

b. Scope of Services
   i. Provide personal hygiene (e.g. sponge bathing, showering, bed shampooing, shaving, oral hygiene dressing);
   ii. While under the supervision of a licensed physical therapist or licensed nurse (RN or LPN), assist with ambulation, transfer and range of motion exercises;
   iii. Assist with menu planning, meal/snack preparation and assist member with eating as necessary;
   iv. 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;
   v. Provide homemaking services (e.g. laundry, linen change, cleaning);
   vi. Pick up medication(s);
   vii. Assist or prompt member in self administration of medication(s);
   viii. Observe general condition of member and report changes to supervisor;
   ix. Document SDCB member’s status and services furnished, infection control procedures; and
   x. Recognize emergencies and adhere to emergency procedures.

c. Home Health Aide Qualifications – Agency Provider
   i. Licensed in New Mexico as a home health agency, rural health clinic or federally qualified health center;
   ii. Possess current business license;
   iii. Meet financial solvency;
iv. Adhere to training requirements;
v. Maintain individual records for each SDCB member within HIPAA compliance;
vi. Develop and adhere to records management policy; and
vii. Develop and adhere to quality assurance policies and processes.
viii. 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.
ix. Ensure all assigned staff meets 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
   a. Definition of Service

Homemaker or Direct Support services are provided on an episodic or continuing basis to assist the SDCB member to accomplish tasks he/she would normally do for him/herself if he/she did not have a disability. Homemaker or direct support services are provided in the member’s home and in the community, depending on the member’s needs. The SDCB member identifies the homemaker or direct support worker’s training needs. If the SDCB member is unable to do the training him/herself, the SDCB member arranges for the needed training.

Providers will bill for services in shared households within state
Homemaker/Direct Support Services include but are not limited to the following:

i. Assist the SDCB member with activities of daily living;
ii. Perform general household tasks, not including services such as yard maintenance;
iii. Provide companionship to acquire, maintain or improve social interaction skills in the community; and
iv. Attend trainings as designated by the SDCB member in the SDCB care plan.

c. Homemaker/Direct Support Qualifications – Individual Provider

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 SDCB 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;
   Complete training on critical incident, abuse, neglect, and exploitation reporting;
v. Complete SDCB member specific training; the evaluation of training needs is determined by the member or his/her legal representative; SDCB 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
vi. Meet any other service qualifications, as specified in the SDCB rules.
d. Homemaker/Direct Support Qualifications – Agency Provider
   i. Home health agencies must hold a home health agency license;
   ii. Possess a current business license, if applicable;
   iii. Meet financial solvency;
   iv. Adhere to training requirements;
   v. Maintain individual records for each SDCB member within HIPAA compliance;
   vi. Develop and adhere to a records management policy; and
   vii. Develop and adhere to quality assurance rules and requirements.
   viii. 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 SDCB 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 screening 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 and Managed Care Policy Manual.

H. NUTRITIONAL COUNSELING
   a. 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.
   b. Scope of Services
      i. Assessment of nutritional needs;
      ii. Development and/or revision of the SDCB member’s nutritional
plan; and

iii. Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

c. Nutritional Counseling Qualifications - Individual Provider:
   i. Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et.seq.

d. Nutritional Counseling Qualifications - Agency Provider:
   i. Current business license; and provide a tax identification number;
   ii. Ensure staff meet the following qualifications:
   iii. 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

a. Definition of Service

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

b. Scope of Services

Private duty nursing services for adults may include performance, assistance and education with the following tasks:
   i. Medication management, administration and teaching;
   ii. Aspiration precautions;
   iii. Feeding tube management, gastrostomy and jejunostomy;
   iv. Skin care;
   v. Weight management;
   vi. Urinary catheter management;
   vii. Bowel and bladder care; Wound care; Health education and screening;
   viii. Infection control;
   ix. Environmental management for safety;
   x. Nutrition management;
   xi. Oxygen management;
   xii. Seizure management and precautions;
   xiii. Anxiety reduction;
   xiv. Staff supervision; and
   xv. Behavior and self-care assistance.

c. Private Duty Nursing Qualifications – Agency
   i. Licensed in New Mexico as a Home Health Agency, Rural Health
Clinic or federally Qualified Health Center (FQHC Agency);
ii. Possess current business license;
iii. Meet financial solvency;
iv. Adhere to training requirements;
v. Maintain individual records for each member within HIPAA compliance;
vi. Develop and adhere to a records management policy; and
vii. Develop and adhere to quality assurance policies and processes.

viii. Ensure all assigned staff meet the following qualifications:
ix. Licensed by the New Mexico State Board of Nursing as a RN or LPN;
x. Demonstrate capacity to perform required tasks;
xi. Be able to communicate successfully with the member;
xii. Complete training on critical incident, abuse, neglect, and exploitation reporting;
xiii. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN; and
xiv. Meet any other service qualifications, as specified in the SDCB rules.

d. Private Duty Nursing Qualifications – Individual
i. Provide a tax identification number;
ii. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN;
iii. Demonstrate capacity to perform required tasks;
iv. Be able to communicate successfully with the SDCB member;
v. Complete training on critical incident, abuse, neglect, and exploitation reporting; and
vi. Meet any other service qualifications, as specified in the SDCB rules.

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

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

b. Scope of Services

Related Goods must address a specific, assessed need identified in the member’s CNA (including improving and maintaining the member’s opportunities for full membership in the community) and must directly relate to the SDCB member’s qualifying condition or disability. Related goods must explicitly address the SDCB member’s clinical functional, medical or habilitative needs.

Related Goods must meet all of the following requirements:

i. Are related to a need or goal identified in the approved care plan;

ii. Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;

iii. Promote opportunities for community living and inclusion;

iv. Are able to be accommodated within the member’s budget without compromising the member’s health or safety; and

v. Are provided to, or directed exclusively toward, the benefit of the member.

c. Medicaid does not pay for the purchase of related goods or services that a household not including a person with a disability would be expected to pay for as a routine household or personal expense. Examples include, but are not limited to:

i. Goods or services that are considered primarily recreational or diversional;

ii. Cell phones and cell phone service for SDCB members who are minors (these are items that legally responsible individuals such as a parent/guardian, or spouse would ordinarily purchase for household members of the same age who do not have a disability or chronic illness);

iii. Cell phone services including fees for data and GPS in excess of $100 per month or more than one cell phone per SDCB member;
iv. Cell phone services that include more than one cell phone or cell phone line per SDCB member; cell phone service, including data, is limited to the cost of one hundred dollars per month;

v. Room and board, meaning shelter expenses (including property-related costs such as home and property maintenance, insurance policies, utilities and all deposits; and all food items other than nutritional supplements as approved in the SDCB care plan);

vi. Purchase of usual and customary furniture/home furnishings,

vii. Regularly scheduled upkeep, maintenance and repairs of a home, addition of fences, insulation, construction of 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;

viii. Regularly scheduled upkeep, maintenance and repairs of a vehicle or van, 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.

ix. Purchase, lease, or rental of a vehicle, including recreational vehicles;

x. Memberships/fees related to religious activities/events;

xi. 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;

xii. Purchase of insurance policies, such as automobile, health, life, burial, renter’s, home-owner, service warrantees or other such policies, including the purchase of cell phone insurance;

xiii. Personal goods or items not related to the SDCB member’s qualifying condition or disability, including clothing and personal hygiene products and accessories;

xiv. Moving expenses including but not limited to the cost of moving truck rental, gas/mileage, labor, storage, moving equipment and supplies;

xv. Vacation expenses, including means of transport, guided tours, meals, tips, lodging or similar recreational expenses including fuel, mileage or driver time reimbursement for vacation travel by an automobile;

xvi. Costs associated with conferences or classes, including airfare, lodging, mileage/gas, or meals;

xvii. Training expenses for employees;
K. RESpite

a. Definition of Service

Respite is to be used to give the primary caregiver a break on an episodic basis in the event of an emergency or to prevent burnout. Respite provides a temporary relief to the primary caregiver of a SDCB member during times when the caregiver would normally provide unpaid care. Respite services can be provided in the SDCB member’s home, the provider’s home, in community setting of the family’s choice (e.g., community center, swimming pool and park, or at a center in which other individuals are provided care).

Respite services may be provided by eligible individual respite providers; licensed registered (RN) or practical nurses (LPN); or respite provider agencies.

b. Scope of Services

Respite services include, but are not limited to the following:

i. For members meeting NFLOC, respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary caregiver. The 100 hour Respite service applies across all community benefit packages where Respite is a covered service. Additional hours may be requested if an eligible beneficiary’s health and safety needs exceed the specified limit.

ii. Assist with routine activities of daily living (e.g. bathing, toileting, preparing or assisting with meal preparation and eating);

iii. Enhance self-help skills, leisure time skills and community and social awareness;

iv. Provide opportunities for leisure, play and other recreational activities;

v. Provide opportunities for community and neighborhood integration;
and involvement;
vi. Provide opportunities for the SDCB member to make his/her own choices with regards to daily activities.

vii. Respite services do not include the cost of room and board;
viii. Cannot be used for purposes of day-care; and

ix. Cannot be provided to school age children during school hours.
c. Respite Qualifications – Individual Provider
   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 SDCB 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; 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;
   vii. Meet any other service qualifications, as specified in the SDCB rules and Managed Care Policy Manual; and
   viii. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN.
d. Respite Qualifications - Provider Agency
   i. Possess a current business license, if applicable;
   ii. Meet financial solvency;
   iii. Adhere to training requirements;
   iv. Maintain individual records for each SDCB member within HIPAA compliance;
   v. Develop and adhere to a records management policy; and
   vi. Develop and adhere to quality assurance rules and requirements.
   vii. 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 SDCB 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 SDCB member specific training; the evaluation of training needs is determined by the SDCB 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 SDBC 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 and Managed Care Policy Manual.

L. SKILLED MAINTENANCE THERAPIES SERVICES
   a. Definition of Service
      Skilled Maintenance Therapies are provided when Medicaid state plan skilled therapy services are exhausted. Adult members in SDCB access therapy services under the Medicaid state plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. A signed therapy referral for treatment must be obtained from the SDCB member’s primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered. Therapy services provided to adults in SDCB are to focus on health maintenance, improving functional independence, community integration, socialization, exercise or to enhance supports and normalization of family relationships.
      i. Physical Therapy is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities.
      ii. 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.
      iii. Speech Language Therapy services preserve speech fluency, voice, verbal, written language, auditory comprehension, cognition, swallowing dysfunction, oral pharyngeal or laryngeal and sensor motor competencies. Speech Language Pathology is also used when a SDCB member requires the use of an augmentative
communication device. Based upon therapy goals, services may be delivered in an integrated natural setting, clinical setting or in a group.

b. Scope of Services
   i. 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 SDCB member’s qualifying condition or disability;
      4. Activities to support the SDCB member’s health and safety needs; and
      5. Identify, implement and train on therapeutic strategies to support the SDCB member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.
   ii. 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 SDCB members, family and staff; and
      6. Identify, implement and train on therapeutic strategies to support the SDCB member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.
   iii. Speech and Language Pathology
      1. Improve or maintain the SDCB 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 SDCB 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 SDCB member, his/her family and/or staff consistent with the member’s SDCB care plan.

iv. Therapy Qualifications – Individual Therapist Provider

1. Provide a tax identification number.
2. Maintain a case file within HIPAA guidelines for the SDCB member to include:
   a. SDCB member’s SDCB care plan;
   b. Reports as requested in the SDCB care plan;
   c. Contact notes;
   d. Training roster(s); and
   e. Assessments for Environmental Modification requests.
3. Licensures:
   a. 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;
   b. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1 et.seq.; and
   c. Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B-1 et.seq.

v. Therapy Qualifications – Provider Agency

1. Current business license;
2. Provide tax identification number;
3. Ensure physical therapists maintain a case file within HIPAA guidelines for the SDCB member to include:
   a. SDCB member’s SDCB care plan;
   b. Reports as requested in the SDCB care plan;
   c. Contact notes;
   d. Training roster(s); and
   e. Environmental Modification requests.
4. Ensure therapists has appropriate license for service
   a. 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.;
   b. Occupational therapists will be licensed as per the New Mexico Regulation and
M. SPECIALIZED THERAPIES SERVICES

a. 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 SDCB member’s disability or condition, and ensure the SDCB member’s health and welfare in the community. The service will supplement to (not replace) the SDCB member’s natural supports and other community services for which the SDCB member may be eligible.

Experimental or investigational procedures, technologies or therapies and those services covered in Medicaid state plans are excluded.

Only the specific specialized therapy services outlined below are covered in the SDCB.

b. Scope of Services:

i. **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.

ii. **Biofeedback** uses visual, auditory or other monitors to provide SDCB members physiological information of which they are normally unaware. This technique enables a SDCB 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.
iii. **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 Chiropractors 16.4.1 NMAC.

iv. **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.

v. **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.

vi. **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.

vi. **Naprapathy** focuses on the evaluation and treatment of neuromusculoskeletal 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.

vii. **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.

c. Specialized Therapy Qualifications – Individual Therapist Provider
   i. 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 SDCB members.

d. Specialized Therapy Qualifications - Provider Agency
   i. Current business license; and
   ii. Provide tax identification number
   iii. 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 (NON-MEDICAL)

a. Definition of Service
   Transportation services are offered in order to enable SDCB members to gain access to and from other community services, activities and resources, as specified by the SDCB care plan. Transportation services are intended for access to the member’s local area, within a 75 mile radius of the SDCB member’s home. Transportation services under SDCB are non-medical in nature, whereas transportation services provided under the Medicaid state plan are to transport members to medically necessary physical and behavioral health services. Transportation for the purpose of picking up pharmacy prescriptions is allowed. Transportation for the purpose of vacation is not covered through the SDCB.

   Non-medical transportation services for minors is not a covered service as these are services that a LRI would ordinarily provide for household
members of the same age who do not have a disability or chronic illness.

Transportation is reimbursed in three (3) different ways to the driver: by the mile; by the trip; or at an hourly rate. It may also be paid through the purchase of a bus pass or local taxi. Payments are made to the SDCB member’s individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the SDCB member. Whenever possible, natural supports should provide this service without charge.

b. Scope of Services
The service will be provided as specified in the SDCB member’s SDCB care plan. SDCB transportation services cannot be used instead of, or to replace, transportation services available under the Medicaid state plan.

Payment is allowable for transportation to and from specific locations/sites that provide specific services that are approved in the member’s care plan goals.

c. Transportation Qualifications - Individual Provider
i. Be at least 18 years of age;
ii. Possess a valid New Mexico driver’s license;
iii. Be free of physical or mental impairment that would adversely affect driving performance;
iv. No driving while intoxicated (DWI) convictions within the previous two (2) years;
v. No chargeable (at fault) accidents within the previous two (2) years;
vii. Have current CPR/First Aid certification;
vii. Complete training on critical incident, abuse, neglect, and exploitation reporting; and
viii. Possess and maintain current insurance policy and registration.

d. Transportation Qualifications – Provider Agency
i. Current business license;
ii. Valid tax identification number;
iii. Have a current basic First Aid kit in the vehicle;
iv. Each vehicle will contain a current insurance policy and registration; and
v. Ensure drivers meet individual qualifications:
   1. Be at least 18 years of age;
   2. Possess a valid New Mexico driver’s 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.

SELF-DIRECTED NON-COVERED SERVICES

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:

1. Services covered by third-parties. The SDCB Program is the payer of last resort;
2. 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.

SDCB BUDGET AND CARE PLAN APPROVAL PROCESSES

Initial Member Entry into FOCoSonline and Working Plan

The care coordinator adds the member to FOCoSonline when the member has expressed a desire to transfer to SDCB by signing the SDCB statement. Once the member selects the support broker agency he/she wishes to work with, the care coordinator informs the support broker agency of the selection. After the support broker meets with the member and an anticipated transfer date is agreed upon, the support broker creates a Working Plan shell with the anticipated SDCB care plan dates. Once the Working Plan shell is created, the care coordinator shall enter the SDCB budget amount in FOCoSonline.

INITIAL SDCB BUDGET DETERMINATION PROCESS

The SDCB budget is determined by the care coordinator and is based on two (2) factors: the needs identified in the CNA, and the amount and type of services the member has been receiving in the ABCB. The care coordinator shall review the existing ABCB services and calculate a dollar amount for the services, using the approved ABCB reimbursement 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 member must receive his/her home and community based services in the ABCB for a minimum of 120 calendar days before transferring to the SDCB. The initial 12-month SDCB budget shall be pro-rated based on the number of months already completed in the ABCB. The SDCB member may request a new CNA if the SDCB member thinks his/her needs were not adequately addressed in the initial CNA.

**INITIAL SDCB CARE PLAN APPROVAL PROCESS**

Once the SDCB care plan is developed, the support broker, in cooperation with the SDCB member, shall inform the care coordinator that the SDCB care plan is ready for review. Once the care coordinator reviews the SDCB care plan, the care coordinator shall formally submit the SDCB care plan in FOCoSonline to the MCO/UR for review and approval/denial decisions. The SDCB member’s SDCB care plan must be reviewed and each individual requested goal approved or denied by the MCO/UR and written notification must be sent to the SDCB member before any SDCB services may be utilized and related goods may be purchased. If, during the process of reviewing the SDCB care plan and all subsequent SDCB care plan revisions, the MCO/UR is unable to make a decision on a goal, due to insufficient information, the MCO/UR shall initiate a “Request For (additional) Information” (RFI) via FOCoSonline. The MCO/UR shall provide written notification to the SDCB member and the support broker, specifying what is needed by the MCO/UR to satisfy the RFI. It is the SDCB member’s responsibility to provide a timely and complete response to the RFI. The support broker/care coordinator may assist the SDCB member in obtaining the requested documents to fulfill the RFI. Member/support broker must provide the RFI response to the care coordinator within 15 calendar days from the date of the RFI letter. After review of the RFI response the care coordinator shall submit the RFI response to the MCO/UR for approval/denial decision. If the requested information is not received by the care coordinator within 15 calendar days from the date of the RFI letter, the service or good shall be denied by the MCO/UR.

If the care coordinator or MCO/UR identifies an administrative error on the submitted SDCB care plan a “Request for Administrative Action” (RFA) shall be sent to the support broker. The RFA shall specify what is needed to correct the administrative error. The support broker must respond to the RFA within five (5) calendar days from the date of the RFA notification. If the RFA is not addressed by the support broker or care coordinator within five (5) calendar days from the date of the RFA letter, the service or good shall be denied by the MCO/UR.

The MCO/UR will notify the SDCB member, care coordinator, and support broker in writing when a determination has been made on the SDCB care plan. The determination may be a full approval, a partial approval, or a full denial. The MCO/UR shall indicate which goal(s) of the SDCB care plan have been approved or denied in FOCoSonline. Written notifications will include steps for the SDCB member/legal representative to follow if the member disagrees with a
The FMA will utilize the approved SDCB care plan/budget to process payment for the approved amount of SDCB services and related goods.

The SDCB member’s SDCB care plan must be approved before SDCB services can begin. The MCO will not issue payment for any SDCB services, supports and/or related goods which are provided or purchased prior to the approval of the SDCB care plan, or before the provider is linked to the SDCB care plan.

At the earliest opportunity, the SDCB care plan and the NFLOC shall be aligned to start/end on the same day. This may entail truncating the existing SDCB care plan to align with the annual NFLOC, or truncating the existing NFLOC to align with the annual SDCB care plan.

**ANNUAL SDCB BUDGET DETERMINATION AND APPROVAL PROCESS**

 Approximately 90 calendar 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. The SDCB budget shall not be higher than the cost of care for persons served in a private nursing facility, unless the member transitioned into SDCB with their prior approved self-directed budget. Unused budget from a previous year cannot be carried over to the new SDCB care plan year.

 Approximately 90 days prior to the expiration of the existing SDCB care plan/budget, the support broker shall open the new Working Plan shell in FOCoSonline, with the begin and end dates for the upcoming SDCB care plan. Upon the annual SDCB budget determination, the care coordinator shall enter the SDCB budget amount in FOCoSonline, allowing the member and support broker to begin developing the upcoming year’s SDCB care plan.

**ANNUAL SDCB CARE PLAN DEVELOPMENT AND APPROVAL PROCESS**

 At a minimum, the SDCB care plan 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 30-calendar day timeframe allows enough time for the care coordinator and MCO/UR to make an informed and accurate determination of all requested SDCB services before the existing SDCB care plan/budget expires. The MCO/UR will notify the SDCB member, care coordinator, and support broker in writing when a determination has been made on the SDCB care plan request. The determination may be a full approval, a partial approval, or a full denial. The MCO/UR shall indicate which goal(s) of the SDCB care plan have been approved or denied in FOCoSonline and a letter shall be sent to the member including written instructions for the member/legal representative to follow if the member disagrees with the denial.
decision(s).

**SDCB BUDGET AND CARE PLAN APPROVAL PROCESS FOR INDIVIDUALS WHO TRANSITIONED (GRANDFATHERED) FROM THE MI VIA WAIVER PROGRAM**

Prior to 1/1/2014, the Mi Via TPA approved many Mi Via employees/vendors at a reimbursement rate which was above the maximum Mi Via rate for a particular Mi Via service. The high reimbursement rate is to continue to be approved in SDCB so long as the specific EOR and SDCB provider relationship does not encounter a break in service. If, for any reason, the relationship ends and a new employee/vendor is hired, the SDCB reimbursement rate for the new SDCB provider shall not exceed the current approved SDCB range of rates (9.A) for any SDCB covered service. When the aforementioned situation occurs, the budget may be reduced by the corresponding amount if the SDCB member has no other legitimate SDCB need(s).

Although Related Goods are not a covered service in ABCB, the need for ‘continuity of care’ exists for Related Goods. When redetermining the annual SDCB budget for SDCB members who transitioned from the Mi Via waiver program, the MCO CC/UM shall allow the currently approved related good(s) and previously approved reimbursement rate to be requested and approved, as deemed appropriate, for each ongoing year of the SDCB care plan/budget.

At each annual assessment and budget determination, the care coordinator shall determine if the SDCB member has underutilized his/her current SDCB care plan/budget. Underutilization is defined as using less than 75 percent of the total budget by the end of quarter three of the SDCB member’s current care plan year. If underutilization has occurred, the care coordinator shall consider reducing the budget by an amount which is no more than the approved total for the underutilized SDCB service for the upcoming SDCB care plan year/budget. However, if underutilization is due to, for example, a temporary hospital admission, and if the hospital admission had not occurred, the member would have utilized SDCB services as requested and approved, the Care Coordinator may not adjust the SDCB budget for the upcoming SDCB care plan year/budget.

If overutilization of the SDCB care plan/budget is identified at any time during the SDCB care plan/year, the MCO shall not increase the current SDCB budget without identifying the need for a new CNA, and determining whether all other available resources have been exhausted prior to requesting additional service(s) through the SDCB. Overutilization is defined as using more than 1) 50 percent of the SDCB budget by the end of quarter two of the SDCB member’s current care plan year, 2) 75 percent of the SDCB budget by the end of quarter three of the SDCB member’s current care plan year, or 3) 100 percent of the SDCB budget by the end of quarter four of the SDCB member’s current care plan year.

Underutilization and overutilization of the SDCB budget may result in an involuntary termination from the SDCB to ABCB depending on the situation; please refer to the SDCB
involuntary termination policy.

**DENIALS, REVISIONS AND RECONSIDERATIONS OF THE SDCB CARE PLAN**

1. **Denials**
   The MCO/UR shall send final decisions to the SDCB member in writing, including steps for the member/legal representative to follow if he/she disagrees with the denial 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.

2. **Revisions**
   The SDCB care plan may be revised 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 natural support system such as the death or disabling condition of a family member or other individual who was providing services.

   If the revision is to provide new or additional services other than those 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 and/or support broker shall assist the SDCB member with exploring other available resources.

   The SDCB member must provide written documentation of the change in needs or circumstances as specified in the Managed Care Policy Manual. The SDCB member submits the documentation to the care coordinator/support broker. In FOCOsonline the member’s legal representative and the support broker initiate the process to modify the SDCB care plan by developing a revision in FOCOsonline and forwarding the completed request for a SDCB care plan revision to the care coordinator who will submit the revision to the MCO/UR for review, via FOCOsonline. At the MCO’s discretion, another CNA may be performed. Per the SDCB rule, if the revision includes a request for additional services, another CNA must be performed to determine whether the change in needs or circumstances necessitate an increase to the SDCB budget.

   The SDCB care plan may be revised 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 or prior SDCB care plan revision request is under initial review by the MCO/UR.

   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. This constraint does not apply to Environmental Modifications requests, as the Environmental Modification work is not
tied to a specific SDCB care plan year and the funding is not part of the overall SDCB budget amount.

Anytime a SDCB member exits SDCB and transfers to ABCB or is permanently institutionalized, the support broker must develop a close-out budget to coincide with the last day the member will receive SDCB services. The only time a close-out budget is not needed is when a member’s care plan will expire in the same month as the member’s final month in SDCB. The close-out budget must be reviewed/approved by the MCO-UR.

3. Reconsiderations
   If the SDCB care plan, or a part of the SDCB care plan, is not approved/denied, the care coordinator and/or support broker assists the SDCB member to explore his/her options, including the right to request a reconsideration of the denial 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 inside FOCoSonline, and additional documentation or additional clarifying information must be submitted in writing, regarding the SDCB member’s request for reconsideration of the denied SDCB services or related goods.

**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:

1. The SDCB services or related goods must be responsive and directly related to the SDCB member’s qualifying condition or disability; and
2. The SDCB services or related goods must address the SDCB member’s clinical, functional, medical or habilitative needs; and
3. The SDCB services or related goods must accommodate the SDCB member in managing his/her household; and
4. The SDCB services or related goods must facilitate activities of daily living; and
5. The SDCB services or related goods must promote the SDCB member’s personal health and safety; and
6. The SDCB services or related goods must afford the SDCB member an accommodation for greater independence; and
7. The SDCB services or related goods must support the SDCB member to remain in the community and reduce his/her risk for institutionalization; and
8. The SDCB services or related goods must be documented in the SDCB member’s SDCB care plan and facilitate the desired outcomes stated in the SDCB member’s SDCB care plan; and
9. The SDCB service or related good is not prohibited by federal and state statutes, rules and guidance; and
10. Each SDCB service or good must be listed as an individual line item; when services or related goods must be ‘bundled’ the SDCB care plan must document why bundling is
necessary and appropriate; and
11. The proposed SDCB care plan is within the SDCB member’s approved budget; and
12. The proposed rate for each SDCB service is within the SDCB range of rates (9.A) for that
chosen service; and
13. The proposed cost for each SDCB good is reasonable, appropriate and reflects the lowest
available cost for that chosen good; and
14. The estimated cost of the SDCB service or good is specifically documented in the SDCB
member’s SDCB care plan.

IMPLEMENTATION OF THE SDCB CARE PLAN

1. Enrolling SDCB Employees and Vendors
   A. Pre Hire Packet
      Before providing SDCB services to a SDCB member, most employees and
vendors are required to submit the appropriate state approved pre-hire packet to
the FMA and pass the Consolidated On-Line Registry (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.

Potential SDCB 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 begins by screening 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 potential SDCB provider has passed the COR check, the EOR will receive an
e-mail notification from the FMA that the potential SDCB employee has passed his/her COR and CBC and may begin providing SDCB services. If the EOR does
not have an e-mail address listed in FOCoSonline, the FMA Help Desk will
contact the EOR, via telephone to let the EOR know that the potential SDCB
employee has passed the COR check. Although an employee may begin providing
services as soon as he/she has passed the COR Background Check, payment will
not be issued until all required paperwork as indicated below is successfully
completed and has been approved by the FMA. If a potential SDCB employee or
vendor does not pass the CBC, as required by NM law, he/she may not continue
to provide services to the SDCB member. The potential SDCB 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
SDCB employee has or has not successfully completed the COR check and/or
CBC.
No SDCB provider shall exceed 40 hours paid work in one (1) work week per EOR. If an employee works for more than one EOR, the employee shall not exceed 40 hours paid work in one (1) work week, per EOR.

B. 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 shall ensure that these requirements are met. These requirements include certain licenses which must be submitted by the potential SDCB provider to the FMA, and are described in 9.B & 9.C (Vendor and Employee Credentialing Requirements). Services cannot be provided to a member until the SDCB care plan is approved, and there is a credentialed and approved provider linked to the approved SDCB goal. Other Required

C. Other Required Documents
There are other documents that must be correctly completed by the potential SDCB employee or vendor, and submitted to the FMA for review and approval before payment can be made. Potential SDCB employees and vendors may obtain these documents may be obtained by contacting the FMA. It is the member/EOR’s responsibility to ensure all employment documents are submitted to the FMA.

D. For potential SDCB employees, the required documents are included in the Employee Packet:
   a. Employment Agreement
   b. Employee Information Form
   c. Declaration of Relationship form
   d. Federal W-4
   e. State W-4

E. For potential SDCB vendors who are providing services the required documents are included as part of the Vendor Packet:
   a. Vendor Agreement
   b. Vendor Information Form
   c. Federal W-9

F. Vendors who are providing SDCB related goods only (such as a large retailer) do not need to provide the Vendor Agreement and Federal W-9, however the SDCB member/EOR or vendor must submit the Vendor Information Form to the FMA before payment is issued.

G. 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.

2. Purchasing Services and Related Goods
A. Timesheets
With access to the FOCOsonline system, a SDCB employee (or EOR) may enter the employee(s)’s timesheet(s) in FOCOsonline. The EOR may then review and approve the timesheet through online access. Having access to FOCOsonline and submitting timesheets online means that the EOR or employees do not need to send the paper 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, the user will receive an e-mail with his/her password and login instructions. Timesheets may also be mailed or faxed to the FMA if the SDCB member of EOR does not have access to a computer or the internet.

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 the FMA and 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 for a SDCB employee to be paid on time and according to the payment schedule.

An Authorized Representative (AR) may also complete the training and gain access to FOCOsonline. If an AR has access, they will be able to view payments and monitor SDCB budget spending, however, the AR will not have authorization to perform the functions of the EOR and approve timesheets. To designate an AR, members must complete the AR Form, which may be requested through the FMA or the support broker.

B. Invoices
Vendor Payment Request Forms (PRF) (9.D) 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. The vendor payment schedule is available through the FMA. Vendor checks are generated by TeleCheck and 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 must 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 or sent electronically to the FMA for processing. If a SDCB member/EOR has access to FOCoSonline, he/she may review his/her payments and monitor them as they are being processed. In addition, the SDCB member, EOR, or AR may run reports through FOCoSonline to monitor spending activity.

C. 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 SDCB 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 to inform the EOR that payment cannot 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 and 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 and 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 for assistance.

D. Employee and Vendor Pay Rates
Employee and vendor pay rates must be approved in the SDCB member’s SDCB care plan. Once the SDCB rate is approved, completed employee agreements and vendor agreements must be submitted to the FMA in order to indicate the rate of pay. If a potential SDCB employee or vendor does not submit an Employee or Vendor agreement, as appropriate, the FMA will not know the correct rate of pay for the service that the employee or vendor is providing. In order for the FMA to pay a SDCB employee or vendor, a complete employee agreement or vendor agreement needs to be submitted to, and approved by, the FMA and the employee/vendor must be linked to the SDCB goal inside FOCoSonline. If the pay rate for an approved SDCB employee or vendor needs to be changed, the new rate must be approved by the MCO via a SDCB care plan revision 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. If a change to a SDCB 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.

E. Timely-Filing Requirements
New Mexico has a 90-calendar day time limit for filing all Medicaid claims and since the 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.

3. 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 and 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 related 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 to each SDCB member/legal representative by the FMA on a monthly basis. The SDCB member may also obtain “real-time” information on service usage and spending by directly accessing FOCoSonline. It is highly recommended that SDCB members obtain access to FOCoSonline so that they can effectively monitor their SDCB care plan/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 for assistance.

The support broker is required to review the SDCB member’s SDCB care plan expenditures during each quarterly face-to-face contact with the SDCB member. The care coordinator and/or 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 the care coordinator will submit it to the MCO/UR for consideration per established procedures. The care coordinator may also initiate a new CNA as needed.

The FMA is responsible for processing payments for approved SDCB services and related 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 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 three (3) attempts to contact the SDCB member by telephone to inform the EOR/member of the insufficient funds issue.
TRANSITIONS, TERMINATION AND REINSTATEMENT PROCESSES

1. Community Benefit Transitions
Upon initial 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 at any time but may not move to SDCB until the first day of the month after 120 calendar days are completed 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. The care coordinator must ensure there is no break in Community Benefit services. If the member has a short term admission, for example 2 weeks, the 120 days does not start over.

Examples of transition include, but are not limited to, the following:
A. The member only has a waiver COE (090, 091, 092, 093 or 094) and is institutionalized more than 60 days, the member must apply for IC and submit their name back on the Central Registry. They then must receive a Community Reintegration allocation. If, when they are discharged, they still have living arrangements in place, they are not required to complete the 120 days again.
B. If the member does not have living arrangements in place, the member must go back to ABCB during the transition and is not mandated to complete another 120 day in ABCB. Meaning, the member can begin self-directing after all living arrangements have been set up and the member is successfully in that living arrangement and the SDCB budget, care plan and employees are approved to provide SDCB covered services.
C. If the member has a full Medicaid COE (001, 003, 004, etc.) and is institutionalized for more than 60 days and the member does not have living arrangements still in place, the member must go back to ABCB during the transition and is not mandated to complete another 120 day. Meaning, the member can begin self-directing after all living arrangement have been set up and the member is successfully in that living arrangement and the SDCB budget, care plan and employees are approved to provide SDCB covered services.

2. Voluntary Termination
SDCB members may transfer from the SDCB to the ABCB at any time. To the extent possible, the SDCB member shall provide his/her SDCB provider(s) with 10 business days advance notice regarding his/her intent to withdraw from the SDCB. All transfers will become effective on the 1st day of the following month.

3. Involuntary Termination
Reasons SDCB members may be involuntarily terminated from the SDCB and offered services through the ABCB include, but are not limited to, the following circumstances:
A. The SDCB member refuses to follow SDCB rules after receiving: focused technical assistance on multiple occasions; and support from the program staff,
care coordinator/support broker, or FMA that is supported with documentation of the efforts to assist the SDCB member. Focused technical assistance is defined as a minimum of three (3) separate occasions where the member /EOR have received training, education or technical assistance, or a combination of both;

B. The SDCB member has 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 the member’s CNA 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 technical assistance, refuses to incorporate the team’s recommendations into his/her SDCB Care Plan, or the SDCB member exhibits behaviors which endanger him/her or others;
   c. 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;
   d. The SDCB member expends his/her entire SDCB budget prior to the end of the SDCB care plan year; or
   e. The SDCB member commits Medicaid fraud such as, for example, altering SDCB employee/vendor payment checks.

C. The final decision to terminate a SDCB member and move him/her to ABCB is made by the state. The MCO shall submit sufficient documentation to the state for approval of the involuntary termination request. Upon state approval, the MCO shall notify the member of the involuntary termination, in writing, and shall include appeal rights per HSD rules. SDCB Involuntary Terminations may become effective any time during the month.

D. Reinstatement to SDCB

Requests to be reinstated back to SDCB may be made one time during a 12-month period. The member must make the request to his/her MCO in writing. All members shall be required to participate in SDCB training prior to their reinstatement.
   a. A SDCB member who voluntarily terminated his/her participation in SDCB may request to move back from ABCB to SDCB any time during a 12-year month period. The final decision to allow the reinstatement to SDCB is at the discretion of the MCO. The care coordinator must ensure the transition does not cause a break in services.
b. A SDCB member who was involuntarily terminated from SDCB may request to be reinstated to SDCB once per 12-month period. The final decision to allow the reinstatement to SDCB is at the discretion of the state. The MCO shall submit sufficient documentation to the state for approval of reinstatement to the SDCB. If approved, the care coordinator shall work with the FMA to ensure that the issues previously identified as reasons for termination have been adequately addressed prior to the reinstatement.

See the Appendices that also relate to SDCB:
- 9.A: Range of Rates and Service Codes
- 9.B: Vendor Credentialing Requirements Grid
- 9.C: Employee Credentialing Requirements Grid
- 9.F: List of SDCB Acronyms
### 9.A: SDCB RANGE OF RATES CHART

<table>
<thead>
<tr>
<th>SDCB SERVICE</th>
<th>BILLING CODE</th>
<th>INTERNAL FOCoS CODE</th>
<th>UNIT</th>
<th>SDCB PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homemaker/Direct Support</td>
<td>99509</td>
<td>99509</td>
<td>Hour</td>
<td>$7.50 (minimum wage) - $14.60</td>
</tr>
<tr>
<td>Home Health Aide</td>
<td>S9122</td>
<td>S9122</td>
<td>Hour</td>
<td>$16.32</td>
</tr>
<tr>
<td>Employment Supports (includes Job Coach)</td>
<td>T2019</td>
<td>T2019</td>
<td>15 min.</td>
<td>$2.15 - $6.93</td>
</tr>
<tr>
<td>Job Developer (Per job that is developed for member)</td>
<td>T2019</td>
<td>T2019JD</td>
<td>Each</td>
<td>$100-$700</td>
</tr>
<tr>
<td>Customized Community Supports (adult day hab.)</td>
<td>S5100</td>
<td>S5100</td>
<td>15 min.</td>
<td>$1.36-$8.82</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>G0151</td>
<td>G0151</td>
<td>15 min.</td>
<td>$13.51 - $24.22</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>G0152</td>
<td>G0152</td>
<td>15 min.</td>
<td>$12.74 - $23.71</td>
</tr>
<tr>
<td>Speech/Language Pathology</td>
<td>G0153</td>
<td>G0153</td>
<td>15 min.</td>
<td>$16.06 - $24.22</td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>H2019</td>
<td>H2019</td>
<td>15 min.</td>
<td>$12.24 - $20.65</td>
</tr>
<tr>
<td>Private Duty Nursing – Adults- RN</td>
<td>T1002</td>
<td>T1002</td>
<td>15 min.</td>
<td>$10.90</td>
</tr>
<tr>
<td>Private Duty Nursing – Adults- LPN</td>
<td>T1003</td>
<td>T1003</td>
<td>15 min.</td>
<td>$6.79</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>S9470</td>
<td>S9470</td>
<td>Hour</td>
<td>$42.83</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>97810</td>
<td>97810</td>
<td>15 min.</td>
<td>$12.50-$25.00</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>90901</td>
<td>90901</td>
<td>Visit</td>
<td>$50.00-$100.00</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>98940</td>
<td>98940</td>
<td>Visit</td>
<td>$50.00-$100.00</td>
</tr>
<tr>
<td>Cognitive Rehab Therapy</td>
<td>97532</td>
<td>97532</td>
<td>15 min.</td>
<td>$12.50-$25.00</td>
</tr>
<tr>
<td>Hippotherapy</td>
<td>S8940</td>
<td>S8940</td>
<td>Visit</td>
<td>$50.00-$100.00</td>
</tr>
<tr>
<td>Massage Therapy</td>
<td>97124</td>
<td>97124</td>
<td>15 min.</td>
<td>$12.50-$25.00</td>
</tr>
<tr>
<td>Naprapathy</td>
<td>S8990</td>
<td>S8990</td>
<td>Visit</td>
<td>$50.00-$100.00</td>
</tr>
<tr>
<td>Native American Healers</td>
<td>S9445</td>
<td>S9445</td>
<td>Session</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Play Therapy</td>
<td>H2032</td>
<td>H2032</td>
<td>15 min.</td>
<td>$12.50-$25.00</td>
</tr>
<tr>
<td>Respite Standard (not provided by RN, LPN or HHA)</td>
<td>T1005</td>
<td>T1005SD</td>
<td>15 min.</td>
<td>$3.38</td>
</tr>
<tr>
<td>Respite RN</td>
<td>T1005</td>
<td>T1005RN</td>
<td>15 min.</td>
<td>$10.90</td>
</tr>
<tr>
<td>Respite LPN</td>
<td>T1005</td>
<td>T1005LPN</td>
<td>15 min.</td>
<td>$6.79</td>
</tr>
<tr>
<td>Respite Home Health Aide</td>
<td>T1005</td>
<td>T1005HHA</td>
<td>15 min.</td>
<td>$4.08</td>
</tr>
<tr>
<td>Emergency Response (monthly fee)</td>
<td>S5161</td>
<td>S5161</td>
<td>Each</td>
<td>$36.71-$40.79</td>
</tr>
<tr>
<td>Emergency Response (testing and maintenance)</td>
<td>S5160</td>
<td>S5160</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td>S5165</td>
<td>S5165</td>
<td>Each</td>
<td>As approved by MCO (maximum of $5,000 every 5 years)</td>
</tr>
<tr>
<td>Service Description</td>
<td>Code 1</td>
<td>Code 2</td>
<td>Per Unit</td>
<td>Approval Status</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Transportation Time</td>
<td>T2007</td>
<td>T2007</td>
<td>Hour</td>
<td>Minimum wage -$14.60</td>
</tr>
<tr>
<td>Transportation Trip</td>
<td>T2003</td>
<td>T2003</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Transportation Mile</td>
<td>T2049</td>
<td>T2049</td>
<td>Per Mile</td>
<td>$0.34-$0.40</td>
</tr>
<tr>
<td>Transportation Commercial Carrier Pass</td>
<td>T2004</td>
<td>T2004</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Fees and Memberships</td>
<td>T1999</td>
<td>T1999CP-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others</td>
<td>T1999</td>
<td>T1999CE-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>(not available for paid caregivers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others</td>
<td>T1999</td>
<td>T1999CL-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>-classes only (not available for paid caregivers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others</td>
<td>T1999</td>
<td>T1999CS-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>-conferences and seminars (not available for paid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>caregivers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technology for Safety and Independence</td>
<td>T1999</td>
<td>T1999TS</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Cell phone service (including data/GPS)</td>
<td>T1999</td>
<td>T1999CELL</td>
<td>Each</td>
<td>$0.00-$100.00</td>
</tr>
<tr>
<td>Cell phone and related equipment</td>
<td>T1999</td>
<td>T1999CPEP</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Cell phone/landline</td>
<td>T1999</td>
<td>T1999CPL</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Internet service</td>
<td>T1999</td>
<td>T1999IS</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Landline service</td>
<td>T1999</td>
<td>T1999LS</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Internet/cell phone</td>
<td>T1999</td>
<td>T1999IC</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Internet/cell phone/landline</td>
<td>T1999</td>
<td>T1999ICL</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Internet/landline</td>
<td>T1999</td>
<td>T1999IL</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Fax machine</td>
<td>T1999</td>
<td>T1999FX</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Computer</td>
<td>T1999</td>
<td>T1999CR</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Office supplies</td>
<td>T1999</td>
<td>T1999OS</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Printer</td>
<td>T1999</td>
<td>T1999PR</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Health-Related equipment and supplies</td>
<td>T1999</td>
<td>T1999HR-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Adaptive equipment and supplies</td>
<td>T1999</td>
<td>T1999AE-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Exercise equipment and related items</td>
<td>T1999</td>
<td>T1999EE-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Nutritional supplements</td>
<td>T1999</td>
<td>T1999NS-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Over the counter medications</td>
<td>T1999</td>
<td>T1999OM-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Household related goods</td>
<td>T1999</td>
<td>T1999HG-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Appliances for independence</td>
<td>T1999</td>
<td>T1999AI-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Adaptive furniture</td>
<td>T1999</td>
<td>T1999AF-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
</tbody>
</table>

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9.B: 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 related 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 related 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.

<table>
<thead>
<tr>
<th>Vendors (Independent Contractors and Agencies) that provide SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ag</strong> = Agency, <strong>IC</strong> = Independent Contractor</td>
</tr>
</tbody>
</table>

<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>97810</td>
<td>Acupuncture</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td><strong>Agency:</strong> Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers:</td>
<td></td>
<td><strong>IC:</strong> Yes</td>
<td><strong>IC:</strong> Acupuncture and/or oriental</td>
</tr>
<tr>
<td></td>
<td>Group Practice or Individual</td>
<td></td>
<td></td>
<td>medicine license</td>
</tr>
<tr>
<td></td>
<td>Specialized Therapist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H2019</td>
<td>Behavior Support Consultation</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td><strong>Agency:</strong> Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers:</td>
<td></td>
<td><strong>IC:</strong> Yes</td>
<td><strong>IC:</strong> Licensed (MD, Clinical</td>
</tr>
<tr>
<td></td>
<td>Individual Behavior Support</td>
<td></td>
<td></td>
<td>Psychologist, Psychologist</td>
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<tr>
<td></td>
<td>Consultant (BSC) or BSC Group Practice</td>
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<td></td>
<td>Associate, SW, LPCC, LPC,</td>
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<td></td>
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<td>Psychiatric Nurse, NM licensed</td>
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<td>marriage and family therapist, NM</td>
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<td></td>
<td>licensed art therapist)</td>
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<tr>
<td>90901</td>
<td>Biofeedback</td>
<td>Visit</td>
<td>Agency: Yes</td>
<td><strong>Agency:</strong> Business License</td>
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<td></td>
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<td></td>
<td><strong>IC:</strong> Yes</td>
<td><strong>IC:</strong> License in Health Care</td>
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<td>Group Practice or Individual</td>
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<td>Specialized Therapist</td>
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<td>includes Biofeedback</td>
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<tr>
<td>98940</td>
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<td>Visit</td>
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<td></td>
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<td></td>
<td>Group Practice or Individual</td>
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<td></td>
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<td></td>
<td>Chiropractor</td>
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<td>T1999CE-I</td>
<td>Coaching Education for Parents, Spouse or Other</td>
<td>Each</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
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<tr>
<td>T1999CS-I</td>
<td>Coaching Education for Parents/Spouse: Conferences and Seminars ONLY</td>
<td>Each</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
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<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>
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<tr>
<td>T1999CL-I</td>
<td>Coaching Education for Parents/Spouse: Classes ONLY Allowed Providers: Vendor</td>
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<td>Agency: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td>97532</td>
<td>Cognitive Rehab Therapy Allowed Providers: Group practice or Individual Specialized Therapist</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License IC: License in Health Care Profession whose scope of practice includes Cognitive Rehab Therapy</td>
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<tr>
<td>S5100</td>
<td>Customized Community Support Allowed Providers: Adult Day Health Agency or Adult Day Habilitation Agency</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<td>T1999CP-I</td>
<td>Fees and Memberships Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
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<td>T1999HR-I</td>
<td>Health-Related Equipment &amp; Supplies Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes</td>
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<td>T1999AE-I</td>
<td>Adaptive Equipment and Supplies Allowed Providers: Vendor</td>
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<td>IC</td>
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<td>T1999EE-I</td>
<td>Exercise Equipment and Related Items</td>
<td>Each</td>
<td>Yes</td>
<td>Yes</td>
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<td>Nutritional Supplements</td>
<td>Each</td>
<td>Yes</td>
<td>Yes</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
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<tr>
<td>Service Code</td>
<td>Service Code Description</td>
<td>Billing Method</td>
<td>Vendor Packet</td>
<td>License and/or Additional Requirements</td>
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<tr>
<td>T1999OM-I</td>
<td>Over-the-Counter Medications</td>
<td>Each</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>S9122</td>
<td>Home Health Aide</td>
<td>Hour</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<tr>
<td></td>
<td>Allowed Providers: Home Health Agency/Homemaker Agency</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Individual Homemaker/Direct Support Provider or Home Health Agency/Homemaker Agency</td>
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<tr>
<td>T1999HG-H</td>
<td>Household Related Goods and Services Hourly</td>
<td>Hourly</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
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<td></td>
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</tr>
<tr>
<td>T1999HG-I</td>
<td>Household Related Goods and Services Item/Invoice</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
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<td></td>
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<tr>
<td>T1999AI-I</td>
<td>Appliances for Independence Item/Invoice</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
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<tr>
<td>T1999AF-I</td>
<td>Adaptive Furniture Item/Invoice</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<td>Allowed Providers: Vendor</td>
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<tr>
<td></td>
<td>Allowed Providers: Supported Employment Provider Agency or Individual</td>
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<tr>
<td>Service Code</td>
<td>Service Code Description</td>
<td>Billing Method</td>
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<td>License and/or Additional Requirements</td>
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<tr>
<td>97124</td>
<td>Massage Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: Massage Therapist License</td>
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<tr>
<td></td>
<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
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<td>IC: Yes</td>
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<tr>
<td>S8990</td>
<td>Naprapathy</td>
<td>Visit</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: Naprapathic Physician License</td>
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<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
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<td>IC: Yes</td>
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<td>S9445</td>
<td>Native American Healers</td>
<td>Session</td>
<td>Agency: Yes</td>
<td>IC: Pre-Hire Packet</td>
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<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
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<td>IC: Yes</td>
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<tr>
<td>S9470</td>
<td>Nutritional Counseling</td>
<td>Hourly</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: Registered Dietician License</td>
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<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
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<td>IC: Yes</td>
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<td>G0152</td>
<td>Occupational Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: OT License</td>
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<tr>
<td></td>
<td>Allowed Providers: Individual Occupational Therapist or Group Practice</td>
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<td>IC: Yes</td>
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<tr>
<td>G0151</td>
<td>Physical Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: PT License</td>
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<td>Allowed Providers: Group Practice or Individual Physical Therapist</td>
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<td>IC: Yes</td>
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<tr>
<td>H2032</td>
<td>Play Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: Licensure in a mental health profession whose scope of practice includes play therapy</td>
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<td></td>
<td>Allowed Providers: Group Practice or Individual Specialized Therapist</td>
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<td>IC: Yes</td>
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<td>T1003</td>
<td>Private Duty Nursing LPN</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License&lt;br&gt;IC: LPN License</td>
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<tr>
<td></td>
<td>Allowed Providers: Home Health Agency, Rural Health Clinic, FQHC or Individual</td>
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<td>IC: Yes</td>
<td></td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Frequency</td>
<td>Agency:</td>
<td>IC:</td>
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<td>T1002</td>
<td>Private Duty Nursing RN&lt;br&gt;Allowed Providers: Home Health Agency, Rural Health Clinic, FQHC or Individual</td>
<td>Per 15 min</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>T1005HHA</td>
<td>Respite Home Health Aide&lt;br&gt;Allowed Providers: Respite Agency</td>
<td>Per 15 min</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>T1005SD</td>
<td>Respite Standard&lt;br&gt;Allowed Providers: Individual Provider (not RN, LPN or HHA) or Respite Provider Agency</td>
<td>Per 15 min</td>
<td>Yes</td>
<td>Yes</td>
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<td>Vendor Packet</td>
<td>License and/or Additional Requirements</td>
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<td>T1005LPN</td>
<td>Respite LPN&lt;br&gt;Allowed Providers: Respite Provider Agency or Individual LPN</td>
<td>Per 15 min</td>
<td>Agency: Yes IC: Yes</td>
<td>Agency: Business License IC: LPN License</td>
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<tr>
<td>T1005RN</td>
<td>Respite RN&lt;br&gt;Allowed Providers: Respite Provider Agency or Individual RN</td>
<td>Per 15 min</td>
<td>Agency: Yes IC: Yes</td>
<td>Agency: Business License IC: RN License</td>
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<tr>
<td>G0153</td>
<td>Speech/Language Pathology&lt;br&gt;Allowed Providers: Individual Speech Language Pathologist (SLP) or Group Practice</td>
<td>Per 15 min</td>
<td>Agency: Yes IC: Yes</td>
<td>Agency: Business License IC: RN License</td>
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<td>T1999TS</td>
<td>Technology for Safety and Independence&lt;br&gt;Allowed Providers: Vendor</td>
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<td>Agency: Yes IC: Yes</td>
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<td>T1999CR</td>
<td>Computer Purchase (item)&lt;br&gt;Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
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<td>T1999PR</td>
<td>Printer Purchase (item)&lt;br&gt;Allowed Providers: Vendor</td>
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<td>T1999FX</td>
<td>Fax Machine Purchase (item)&lt;br&gt;Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<td>T1999CPEP</td>
<td>Cell Phone and Related Equipment Purchase (item)&lt;br&gt;Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<td>T1999IS</td>
<td>Internet Service&lt;br&gt;Allowed Providers: Vendor</td>
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<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<td>T1999CELL</td>
<td>Cell Phone Service&lt;br&gt;Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
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<tr>
<td>Code</td>
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<td>Payment Method</td>
<td>Agency</td>
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<td>T1999LS</td>
<td>Landline Service</td>
<td>Each</td>
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<td>T1999ICL</td>
<td>Internet/Cell Phone/Landline Service (bundled)</td>
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<tr>
<td>T1999IC</td>
<td>Internet/Cell Phone Service (bundled)</td>
<td>Each</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>T1999IL</td>
<td>Internet/Landline Service (bundled)</td>
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<tr>
<td>Service Code</td>
<td>Service Code Description</td>
<td>Billing Method</td>
<td>Vendor Packet</td>
<td>License and/or Additional Requirements</td>
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<tr>
<td>T1999CPL</td>
<td>Cell Phone/Landline Service (bundled)</td>
<td>Each</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
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<td>IC: Yes</td>
<td></td>
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<td>T1999OS</td>
<td>Office Supplies (purchased as items)</td>
<td>Each</td>
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<td>VIF is required (goods only)</td>
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<td></td>
<td>Allowed Providers: Vendor</td>
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<td>IC: Yes</td>
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<tr>
<td>T2004</td>
<td>Transportation Commercial Carrier Pass</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>VIF is required (goods only)</td>
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<tr>
<td></td>
<td>Allowed Providers: Transportation Commercial Carrier</td>
<td></td>
<td>IC: Yes</td>
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<tr>
<td>T2007</td>
<td>Transportation Time</td>
<td>Hourly</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<tr>
<td></td>
<td>Allowed Providers: Transportation Agency or Individual Driver</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Transportation Appendix, Pre-Hire Packet</td>
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<tr>
<td>T2003</td>
<td>Transportation Trip</td>
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<td>Agency: Business License</td>
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<td>Allowed Providers: Transportation Agency or Individual Driver</td>
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<td>IC: Yes</td>
<td>IC: Transportation Appendix, Pre-Hire Packet</td>
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<td>T2049</td>
<td>Transportation Mile</td>
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<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<td></td>
<td>Allowed Providers: Transportation Agency or Individual Driver</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Transportation Appendix, Pre-Hire Packet</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.

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 question.
9.C: EMPLOYEE CREDENTIALING REQUIREMENTS GRID

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>
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<tbody>
<tr>
<td>Employment Supports (includes Job Coach)</td>
<td>T2019</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<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.
Use these tips for completing Invoices!

Q: What is this toolkit for?

A: This toolkit explains how to make the invoice process work smoothly! Members/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 CONDUENT (formerly 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 CONDUENT 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 CONDUENT 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,
  - Smith Industries, LLC is your legally registered business name with State of New Mexico. This is the name you must use on your invoice!
- Bobby Smith is your personal name. Do not use!
- 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: CONDUENT PO Box 27460, Albuquerque, NM 87125

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)
Member Name: __ Pauline Participant ________________ Member 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>Member 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>

\*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.

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: __________
Total Charge: $81.06

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.

Example:

<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>Member present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.25.11</td>
<td>S9470</td>
<td>4</td>
<td>12.00</td>
<td></td>
<td>50</td>
<td>$45.00</td>
<td>Nutritional Counseling</td>
<td>□ Y □ N</td>
</tr>
<tr>
<td>04.26.11</td>
<td>T2649</td>
<td>1</td>
<td>0.034</td>
<td></td>
<td>50</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>T2633</td>
<td>1</td>
<td>25.00</td>
<td></td>
<td>1</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
Total Charge: $90.00

This form MUST be attached to the Payment Request Form (PRF) for all services.
9.E: EMPLOYEE TOOLKIT

Toolkit: Timesheets

Q: What is this toolkit for?
A: This toolkit explains how to make the timesheet process work smoothly! Members/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 July 15, 2011, timesheets that are received by CONDUENT 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 CONDUENT (via fax or the FOCoSonline 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 CONDUENT 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 Self-Direction 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 20\textsuperscript{th}, you cannot enter time for services you will provide on Monday, May 23\textsuperscript{rd} 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 member/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

- **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.
# 2-Week Self-Direction Timesheet for Payment

<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>AM 10:00</td>
<td>2</td>
<td>99509</td>
<td>Prepared meals, shopped for groceries.</td>
</tr>
<tr>
<td>05/08/2011</td>
<td>AM 8:00</td>
<td>AM 11:00</td>
<td>3</td>
<td>99509</td>
<td>Picked up Pauline’s prescriptions at pharmacy, helped her with laundry.</td>
</tr>
<tr>
<td>05/09/2011</td>
<td>AM 8:00</td>
<td>AM 11:00</td>
<td>3</td>
<td>99509</td>
<td>Helped Pauline pack for trip to visit brother.</td>
</tr>
<tr>
<td>05/10/2011</td>
<td>AM 6:00</td>
<td>AM 8:00</td>
<td>6</td>
<td>H2021</td>
<td>Took Pauline to event at library.</td>
</tr>
<tr>
<td>05/11/2011</td>
<td>AM 10:00</td>
<td>AM 12:00</td>
<td>2</td>
<td>99509</td>
<td>Cleaned apartment.</td>
</tr>
<tr>
<td>05/12/2011</td>
<td>AM 10:00</td>
<td>AM 12:00</td>
<td>2</td>
<td>99509</td>
<td>Prepared meals for next week.</td>
</tr>
<tr>
<td>05/14/2011</td>
<td>AM 11:00</td>
<td>AM 12:00</td>
<td>3</td>
<td>99509</td>
<td>Laundry, cleaned apartment.</td>
</tr>
<tr>
<td>05/15/2011</td>
<td>AM 12:00</td>
<td>AM 3:00</td>
<td>3</td>
<td>99509</td>
<td>Taught Pauline how to use computer.</td>
</tr>
<tr>
<td>05/16/2011</td>
<td>AM 2:00</td>
<td>AM 5:00</td>
<td>6</td>
<td>99509</td>
<td>Worked with Pauline on practicing better safety skills at home.</td>
</tr>
<tr>
<td>05/17/2011</td>
<td>AM 8:00</td>
<td>AM 4:00</td>
<td>8</td>
<td>99509</td>
<td>Worked with Pauline on washing dishes and cleaning the apartment.</td>
</tr>
<tr>
<td>05/18/2011</td>
<td>AM 8:00</td>
<td>AM 1:00</td>
<td>5</td>
<td>99509</td>
<td>Prepared frozen meals for next week.</td>
</tr>
</tbody>
</table>

## Total Hours for Week 1 + Week 2

<table>
<thead>
<tr>
<th>Total Hours for Week 1</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hours for Week 2</td>
<td>24</td>
</tr>
</tbody>
</table>

**Midnight Rule:**
10PM – 12AM (1st day) - 12AM – 1AM (2nd day)

**Split Shift:**
8AM – 11AM Homemaker/Direct Support Services
2PM – 8PM Community Direct Support/Negotiation
### LIST OF ACRONYMS

#### CENTENNIAL CARE, 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>
10 MANAGED CARE COST SHARING

Revision dates: August 15, 2014
Effective date: January 1, 2014

NEW MEXICO MEDICAID PROGRAM COPAYMENTS (Revised version 8-6-2014, Effective 8-1-2014)

<table>
<thead>
<tr>
<th>CHIP RECIPIENT COPAYMENTS</th>
<th>Children’s Health Insurance Plan Categories of Eligibility 071, 0420, and 0421</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayment only applies when the federal match code is 1</td>
<td></td>
</tr>
</tbody>
</table>

**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 practitioners, dental visit, therapy session, or behavioral health service session - 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, the copayment is always applied to the hospital charge, not the professional charge.

$25 inpatient admission – Not applied when the hospital receives recipient as a transfer from another hospital.

**EXEMPTIONS** from copayments for unnecessary brand name drug use or ER use:
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.

**COPAYMENTS FOR UNNECESSARY SERVICES:**
$3 for unnecessary use of 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 4, note 2. Psychotropic drug items are exempt from the brand name copayment.

$8 for non-emergent use of ER – See note section on page 4, note 1.

**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 6, item 8 of note 3; and on page 6, item 12 of note 3.
6. When there is a NF LOC used for community benefits, NF stays, or other residential care.
11 MARKETING

Revision dates: August 15, 2014, September 1, 2016
Effective date: January 1, 2014

1. 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.

2. 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 MCO’s enrolled 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 MCO’s enrolled members or health promotion incentives used to motivate members to adopt a healthy lifestyle and/or obtain specific health care services. These may include but are not limited to:
   
   A. infant car seats or baby item giveaways
   B. gift cards
   C. manufacturer or coupons for savings on products; or
   D. services 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 MCO’s or subcontractor’s membership or to “Brand” a MCO’s or subcontractor’s 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 MCO’s or subcontractor’s 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 MCOs and subcontractors, including providers (e.g. personal care providers).

**Outreach:** Any means of educating or informing the MCO’s 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 MCO’s 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.

**Provider:** A hospital/hospital staff, physician/physician staff, pharmacy/pharmacist, ancillary service providers and their staff, personal care/homemaker providers and their staff.

3. **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 Centennial 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 market, outreach, retention activities and materials, the MCO must submit for review and prior approval to HSD. In addition to the approval, the MCO must provide HSD with a copy of the approved materials, advertising copy or publication in which the ad will be placed.

**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 MCO’s submission for review and approval by HSD.

MCOs shall review all material on a regular basis and revise materials as necessary. Any revised or updated material previously approved must be submitted to HSD for approval.

**B. Events**

MCOs may participate in health-related marketing and outreach events.

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 in which the MCO participated. 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.

C. Marketing and Outreach Plan
The MCO shall submit an annual Marketing & Outreach Plan as well as a quarterly report which outlines the MCO’s activities.

D. 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 their health plan name and logo use to prevent misuse.

E. HSD Marketing Committee Approval
The HSD Marketing Committee will attempt to approve or deny marketing requests within 15 business days of the receipt of the complete request. The “15 day” timeframe for approval or denial shall only apply to the specific date of the initial submission. Modifications of any type would need to be resubmitted, which may delay approval.

F. 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 MCO’s 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 MCO’s 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 MCO’s subcontractors;
j. Discriminatory marketing practices; and
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 its subcontractor may not complete any portion of the application forms on behalf of the potential enrollee. The prohibition covers all situations, whether sponsored by the MCO, its parent company, or any other entity.
I. HSD reserves the right to impose additional restrictions at any time.

4. HSD REVIEW OF MCO MATERIALS
The MCO shall ensure that all materials submitted to HSD for review meet the following criteria:
A. 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.
B. All materials two or more pages must be numbered.
C. 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.
D. 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.
E. 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.
F. 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).
G. 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.
H. All materials shall specify “Such services are funded in part with the State of New Mexico”.
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.

5. SANCTIONS/PENALTIES
Any violation of this policy may result in the sanctions as described in 7.3 of the contract.

The MCO shall ensure that subcontractors are advised that they 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.

Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.

Subcontractors may only advertise the services they provide and may not make any reference to HSD/MAD Programs, Medicaid or services that the MCO 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 via the following:

- Television advertising
- Internet advertising
- Print advertising;
- Radio advertising;
- Billboards;
- Bus Wraps (including bus stops)

The MCO will monitor its subcontractors found in violation of this policy and impose 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, or at HSD’s discretion, to determine if the MCO or its subcontractor is now deemed complaint.

6. REFERENCES
B. HSD/MAD Managed Care Contract
12 PATIENT CENTERED INITIATIVES

Revision Dates: August 15, 2014, September 1, 2016
Effective Date: January 1, 2014

BROAD STANDARDS:

The Managed Care Organization (MCO) shall establish patient centered initiatives 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.

1. The MCO shall develop patient-centered, “whole person” models of care that is uniform across payers and tailored to the diverse needs and capacities of primary care practices, large and small, urban, rural and frontier. The NM model should be based upon nationally accepted standards.

2. This model will be a blended model that builds upon the work that has already been done by practices that have achieved certification programs. This blended model will include a pathway towards certification for those practices that do not currently have the capacity to attain certification.

3. The NM PCMH program will provide technical assistance, benchmarks and financial support to practices in order to move them along the pathway towards national recognition. Payment to NM PCMH practices is standardized and based on level of PCMH achievement and continued evidence of quality care to patients and reduced cost. New Mexico PCMH will include state specific goals tailored to the unique needs of communities and patients.

4. Core Components of the NM PCMH Model include:
   A. Administrative:
      a. Adopt a standard model for PCMH that includes national certification by NCQA, AAHC and the Joint Commission
      b. Develop a “Glide Path” to certification that is open to all practices seeking PCMH status
      c. Provide technical assistance and hands on training for practices working towards PCMH certification
      d. Simplify, coordinate and standardize practices across MCOs specifically: claims, prior authorizations, and other administrative processes
   B. Clinical:
      a. Improved access to care through flexible scheduling, accommodating walk-ins, providing after hours and weekend office hours
b. Team-based care – provider teams based in clinics collaborate with community health workers, lactation consultants, public health workers, and other community members

c. Integration/ co-location of behavioral health services – mental health and substance use - including SBIRT

d. Include school based health centers and other non-traditional healthcare settings

e. Patient-centered care - engage patients in their own healthcare decisions, respect for patient values and culture and inclusion of patient care givers

f. Coordination of care

i. Develop a care coordination collaborative that operates across payers at the point of care (in the healthcare office or other community location)

ii. Prioritize communities of highest need

iii. Address social determinants of health i.e. housing, food, transportation, etc.

iv. Seamless transition between services and providers

v. Integration of Public Health services – ex. Children’s Medical Services (CMS) care coordination for children with special healthcare needs, Women Infants and Children (WIC), sexually transmitted infection treatment and contact tracing, etc.

g. Integration of Public Health services – ex. Children’s Medical Services (CMS) care coordination for children with special healthcare needs, Women Infants and Children (WIC), sexually transmitted infection treatment and contract tracing, etc.

C. Data

a. Create a health care provider and practice database for the state

b. Use data to inform the health system

i. All payer claims data base

ii. Health information exchange

iii. Employ evidence based interventions

c. Providers report on measures that reflect State-level health priority areas with a life course approach and utilizes health equity as a foundational lens

d. Commitment to data integration and sharing information in real time to improve quality and lower costs, and to improve population health

D. Payment

a. Standardize a payment approach for PCMH that includes practices that have not yet attained certification but are working on improving quality, access and other core components of PCMH

b. Would have a shared saving model among providers.

c. Value based payments based on patient healthcare outcomes
d. Align payment models to specific kinds health care

E. Specific Actions Related to Policy
   a. Improve reciprocity laws so that licensed professionals from other states can transfer to New Mexico easily
   b. Support Tribal 638 programs to become Federally Qualified Health Centers under 330

HEALTH HOMES

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.

The MCO shall ensure that the Health Homes provide the delegated care coordination functions for Members enrolled with the Health Home. Delegated Health Home Care Coordination responsibilities include the following:

1. Perform a Comprehensive Needs Assessment (CNA) for Health Home Members who meet the criteria. For members of the Health Home using the Treat First Model, an in-home visit will be required within 6 months;
2. Assign Care Coordination levels for each Health Home Member;
3. Adhere to Care Coordination activities for level 2 or level 3 as set forth in the HSD Policy Manual;
4. Develop and implement Comprehensive Care Plans (CCP) for Members in Care Coordination levels 2 and 3 to monitor, on an ongoing basis, the effectiveness of the care coordination process;
5. Develop and implement policies and procedures for ongoing identification of Members who may be eligible for a higher level of care coordination;
6. Develop and implement policies and procedures for ongoing care coordination to ensure that Members receive all necessary and appropriate care;
7. Monitor and evaluate a Member’s emergency room and behavioral health crisis services utilization;
8. Participate in the institutional setting’s care planning process and discharge planning processes;
9. Maintain individual case files for each Member;
10. Ensure adequate care coordination staffing requirements, including training required to perform the care coordination activities;
11. Ensure that Members transition to another MCO in accordance with HSD’s protocols.
The MCO will provide available Member documentation to the Health Home, including but not limited to:

1. History & Physical
2. Individualized Service Plan
3. HRA
4. CNA
5. Functional Assessment
6. CCP
7. Emergency & Back-up Plan
8. Behavioral Health Co-Management summary notes
9. Advance Directive

The MCO will provide training to the Health home Agencies regarding the criteria indicating a Health Home Member may be eligible for a Nursing Facility Level of Care (NF LOC). The Health Home Care Coordinator and the MCO Care Coordinator will conduct the NF LOC assessment together for Members who meet the criteria. The MCO will complete the Allocation Tool and develop the Community Benefit section of the Member’s CCP. The Health Home Care Coordinator will coordinate and monitor the utilization of the Community Benefit Services. The MCO will retain the budget for Members who utilize Self-Directed Community Benefits (SDCB). The Health Home Care Coordinator will conduct the Care Coordination and Care Management for the Health Home Member.

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.

**HEALTH HOMES CORE SERVICES:**

1. Comprehensive Care Management must include:
   A. Assessment of preliminary risk conditions and health needs;
   B. 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;
   C. Assignment of health team roles and responsibilities;
   D. Development of treatment guidelines for health teams to follow across risk levels or health conditions;
   E. Oversight of the implementation of the Care Management Plan which bridges treatment and wellness support across behavioral health and primary care;
F. 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

G. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.

2. Care Coordination is the implementation of the individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports. Developed in active partnership with the member and the member’s family, as appropriate, 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. Specific activities include, but are not limited to:

A. Appointment scheduling;
B. Conducting referrals and follow-up monitoring;
C. Participating in hospital discharge processes;
D. Communicating with other providers and client/family members;
E. Comprehensive Transitional Care;
F. Coordinating plans of care;
G. Reducing hospital admissions;
H. Easing the transition to long term services and supports; and
I. Interrupting patterns of frequent hospital emergency department use.

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.

3. Health Promotion services must include:

A. Provide health education specific to an individual’s chronic conditions;
B. Development of self-management plans with the individual;
C. Education regarding the importance of immunizations and screening for overall general health;
D. Providing support for improving social networks;
E. 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
F. Reinforce strategies that support the member’s motivation to better understand and actively self-manage her or his chronic health condition.

4. Individual and Family Support services must include, but are not limited to:

A. Navigating the health care system to access needed services;
B. Assisting with obtaining and adhering to medications and other prescribed treatments;
C. Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
D. Arranging for transportation to medically necessary services.
5. Referral to Community and Social Support Services must include:
   A. Identifying available community-based resources; and
   B. Actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement;
      a. 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.

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.
This section of the policy manual is issued to address the criteria and process for determining whether a member in the Other Adult Group category of eligibility (COE 100) is Medically Frail. A Medically Frail member in COE 100 may choose to continue receiving services under the Alternative Benefit Plan (ABP) services package, or may choose to become ABP Exempt and receive services under the Medicaid State Plan benefit package.

ABP Exempt means an Other Adult Group Medicaid (COE 100) recipient who has been determined as meeting the definition and criteria of Medically Frail and has chosen to receive services under the Medicaid State Plan benefit package instead of the ABP. All COE 100 members are notified of their enrollment in the ABP and of the Medically Frail exemption criteria/process on their Human Services Department (HSD) Medicaid eligibility notice. The eligibility notice also directs ABP recipients to the HSD/Medical Assistance Division (MAD) website where they can find the full listing of ABP benefits and a comparison to the Medicaid State Plan. This section of the policy manual explains the detailed criteria that should be used by the MCO to determine whether COE 100 members meet one of the definitions of Medically Frail.

DETERMINATION OF MEDICALLY FRAIL DIAGNOSIS

Members in COE 100 may self-identify to the MCO by telephone that they believe they may be Medically Frail, and may do so at any time during their eligibility for COE 100. Members in COE 100 may also be identified as potentially Medically Frail by the MCO through the care coordination process.

To determine whether a member qualifies as Medically Frail, the MCO should reference the Medically Frail Conditions List. The member must have a documented medical diagnosis from the list of qualifying conditions. A written statement from a licensed provider attesting to the medical condition will suffice. The entire medical record is not needed. If obtaining a written statement will cause significant delay, the MCO may confirm the diagnosis by a licensed provider over the telephone. If the diagnosis is confirmed by telephone, the MCO should document that the discussion occurred and the outcome of that conversation. The MCO should determine which staff can perform this function. A nurse is not required.

There shall be no end date for a Medically Frail approval. Upon the member’s self-identification, or through the MCO’s care coordination process, the MCO shall evaluate and confirm whether the member qualifies as Medically Frail. The MCO shall confirm the member’s status and notify the member whether they meet the criteria for ABP Exempt by mail within 10 business days of the
member’s self-identification. If the MCO is unable to obtain a provider’s diagnosis or any requisite follow-up from either the member or a provider after making a good faith effort to do so within the necessary timeframe, then the MCO should issue a technical denial letter to the member.

The ABP member remains enrolled in the ABP until the MCO has confirmed Medically Frail status and the member has chosen to receive the ABP Exempt benefit package. The MCO shall describe the benefit and cost-sharing differences between the ABP and the full Medicaid benefit package, if requested by the member.

**ABP EXEMPT APPROVAL**

If the member chooses the ABP Exempt benefit package, the MCO shall 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) within two business days of receiving a call from a Medically Frail COE 100 member choosing the ABP Exempt benefit package; and shall mail the ABP Exempt member an approval letter. The entry in Omnicaid should be made in the Client Detail window in the Client Subsystem, and may be made at any time during the month.

If the member does not meet Medically Frail criteria, the MCO shall mail the member a denial letter. Should the member disagree with the MCO’s determination about his/her ABP Exempt status, the member may file a reconsideration or request a fair hearing through the MCO’s appeals process. If a member does not have one of the conditions or diagnoses listed on the Medically Frail Conditions List and the member believes that his/her condition should be considered for inclusion, then a request may be sent to HSD/MAD to include it. The HSD/MAD Medical Director will review the request to determine whether the individual’s condition should be added.

See the following appendices:
13.A: ABP Benefit Chart
13.C: Chronic Substance Use Disorder (SUD) Criteria Checklist
13.D: Serious Mental Illness (SMI) Criteria Checklist
13.E: NF LOC Supplement
Exhibit 13.A: ABP Benefit Chart

Medicaid Alternative Benefit Plan (ABP) 1-8-2014

RECIPIENT DEFINITIONS

Note that there are 2 kinds of ABP recipients:

1. 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.

2. 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.

a) 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:
A. 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.

   a. 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

   b. 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.

   c. 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.

   d. 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 hearings 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.
   a. 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.
   b. 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.

1. Acupuncture
2. Infertility treatment
3. Naprapathy
4. Temporomandibular joint (TMJ) and cranial mandibular joint (CMJ) treatment
5. Weight loss programs
6. 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:

1. Community benefits
2. Nursing facility care, except as a temporary step down level of care from a hospital prior to being discharged to home
3. 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. Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.</td>
<td>Covered under EPSDT if medically necessary (perhaps unlikely) without the life time limit. 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 - except for items that are related to prenatal care; low dose aspirin for preventing</td>
<td>Covered using the same provisions as for recipient under EPSDT in the standard Medicaid program.</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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<tr>
<td>cardiac events; treatment of diabetes, items used for contraception (foams, devices, etc.) Note that coverage of diabetic test strips, and similar items are described under medical supplies, below. 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>covered using the same provisions as for children under EPSDT in the standard Medicaid program.</td>
<td></td>
</tr>
<tr>
<td>Glasses and contact lens Not covered except for aphakia (following removal of the lens.) 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>covered using the same provisions as for children under EPSDT in the standard Medicaid program.</td>
<td></td>
</tr>
<tr>
<td>Hearing aids Not covered. 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. Hearing testing by an audiologist or a hearing aid dealer is not a benefit.</td>
<td>covered using the same provisions as for children under EPSDT in the standard Medicaid program.</td>
<td></td>
</tr>
<tr>
<td>Home health services Limited to 100 visits annually – a visit cannot exceed 4 hours. An MCO has the option of providing these services through private duty nursing and nursing registry personnel</td>
<td>covered under EPSDT without the limitation on the dollar amount or length of visits.</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. 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>
<td></td>
</tr>
<tr>
<td>SERVICE</td>
<td>LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE</td>
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<td>-----------------------------------------------------------------</td>
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</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 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. 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>
<td></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>
</tbody>
</table>
| Rehabilitation and Habilitation  
- Physical therapy  
- Occupational therapy  
- Speech and language pathology | 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. | Covered under EPSDT without the limitation on duration. |
### SERVICE LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE

**FOR AGES 19 AND 20 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**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended care hospitals (long term care</td>
<td>Other than the above one-time extension, therapy services extending</td>
</tr>
<tr>
<td>hospitals)</td>
<td>beyond the two-month period from the initial date of treatment are</td>
</tr>
<tr>
<td></td>
<td>considered long-term therapy and are not covered.</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>Not covered</td>
</tr>
<tr>
<td>Transplants</td>
<td>Limited to 2 per lifetime</td>
</tr>
</tbody>
</table>

**Extended care hospitals (long term care      Extended care hospitals are not covered. Sometimes these are referred   |
| hospitals)                                   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.    |

**Sleep studies**

Not covered

**Transplants**

Limited to 2 per lifetime

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care, annual physicals, etc.</td>
<td>Under preventive care, a large range of services are covered as part</td>
</tr>
<tr>
<td></td>
<td>of or in addition to the preventative care exam. See extended</td>
</tr>
<tr>
<td></td>
<td>comments on the preventive services, item 4, at the end of this</td>
</tr>
<tr>
<td></td>
<td>document.</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>MAD benefits for the Autism Spectrum diagnosis is being extended up</td>
</tr>
<tr>
<td></td>
<td>through age 20 as an EPSDT benefit.</td>
</tr>
</tbody>
</table>

### 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.
However, in order to be comparable to commercial plans, the ABP plan also includes ages 21 and 22 for this benefit.

<table>
<thead>
<tr>
<th>Disease management</th>
<th>Skilled nursing is generally provided only through a home health agency under the Medicaid fee for service program. However, an MCO can also provide skilled nursing through private duty nursing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electroconvulsive therapy (ECT)</td>
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<tr>
<td>Educational materials and counseling for a healthy life style</td>
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<tr>
<td>Nutritional counseling</td>
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<tr>
<td>Skilled nursing</td>
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</tr>
</tbody>
</table>

4. NOTES ON THE COVERAGE OF PREVENTIVE CARE SERVICES FOR ABP RECIPIENTS

1. 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.

2. Additionally, for recipients who are age 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 of 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 screening: men</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>Alcohol misuse: screening and counseling</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>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>
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<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
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<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>
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<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>
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<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>
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<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>
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<td>Service</td>
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<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>
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<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>
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<tr>
<td>Chlamydial infection screening: nonpregnant women</td>
<td>The USPSTF recommends screening for 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>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
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<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>
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<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>
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<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>
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<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>
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<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>
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<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>
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<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care</td>
<td>Covered – already in MC coverage requirements.</td>
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<td>supports are in place to assure accurate</td>
<td>The “depression care supports” component does not have to include any provider types not currently covered by the Medicaid program.</td>
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<td>diagnosis, effective treatment, and follow-up.</td>
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<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>
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<tr>
<td>Falls prevention in older adults: exercise</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 requirement is to pay for the exercise class or physical therapy.</td>
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<tr>
<td>Falls prevention in older adults: vitamin D</td>
<td>The USPSTF recommends vitamin D supplementation to prevent falls in community-</td>
<td>Covered – already in MC coverage</td>
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<td>dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>requirements or as a standard Medicaid recipient state plan service.</td>
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<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>
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<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>
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<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 women at their first prenatal visit.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this</td>
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<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>
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<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 appropriate services.</td>
<td>Covered – already in MC coverage requirements.</td>
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<td>Service</td>
<td>USPSTF Recommendations</td>
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<tr>
<td>Osteoporosis screening: women</td>
<td>The USPSTF recommends screening for osteoporosis in women age 65 years and older and</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
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<td>in younger women whose fracture risk is equal to or greater than that of a 65-year-old</td>
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<td>white woman who has no additional risk factors.</td>
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<tr>
<td>Rh incompatibility screening: first</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
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<tr>
<td>pregnancy visit</td>
<td>women during their first visit for pregnancy-related care.</td>
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<tr>
<td>Rh incompatibility screening: 24–28</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
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<tr>
<td>weeks’ gestation</td>
<td>negative women at 24 to 28 weeks’ gestation, unless the biological father is known to</td>
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<td>be Rh (D)-negative.</td>
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<tr>
<td>Sexually transmitted infections</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually trans-</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
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<tr>
<td>counseling</td>
<td>mitted infections (STIs) in all sexually active adolescents and for adults at increased</td>
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<td></td>
<td>risk for STIs.</td>
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<tr>
<td>Skin cancer behavioral counseling</td>
<td>The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24</td>
<td>Broader requirement than currently exists as a standard Medicaid recipient service.</td>
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<td>years who have fair skin about minimizing their exposure to ultraviolet radiation to</td>
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<td>reduce risk for skin cancer.</td>
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<tr>
<td>Tobacco use counseling and interventions: nonpregnant adults</td>
<td>The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>Broader 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>
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</tbody>
</table>
In order for a Category of Eligibility (COE) 100 (Other Adult Group) Medicaid recipient 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>Condition</th>
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<th>Condition</th>
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<tbody>
<tr>
<td>Acquired Immune Deficiency Syndrome (AIDS)</td>
<td>ALS (Lou Gehrig’s Disease)</td>
<td>Angina Pectoris</td>
<td>Arteriosclerosis Obliterans</td>
<td>Artificial Heart Valve</td>
<td>Ascites</td>
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<tr>
<td>Blindness</td>
<td>Cancer (current diagnosis/treatment, within five years)</td>
<td>Cardiomyopathy</td>
<td>Chronic Substance Use Disorder – refer to the Substance Use Disorder (SUD) Criteria effective August 2015 (or subsequent replacement version)</td>
<td>Cirrhosis of the Liver</td>
<td>Compromised Immune System</td>
</tr>
<tr>
<td>Coronary Insufficiency</td>
<td>Coronary Occlusion</td>
<td>Crohn’s Disease</td>
<td>Cystic Fibrosis</td>
<td>Dermatomayositis</td>
<td>Diabetes (Insulin Dependent)</td>
</tr>
<tr>
<td>Disability: A physical, intellectual or developmental disability that significantly impairs the ability to perform 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>
<td>Friedreich’s Disease</td>
<td>Hemophilia</td>
<td>Hepatitis C (Active)</td>
<td>HIV+</td>
<td>Hodgkin’s Disease</td>
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<tr>
<td>Huntington’s Chorea</td>
<td>Hydrocephalus</td>
<td>Intermittent Claudication</td>
<td>Juvenile Diabetes</td>
<td>Kidney Failure</td>
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<td>Condition</td>
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<td>Lead Poisoning with Cerebral Involvement</td>
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<td>Leukemia</td>
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<td>Lupus Erythematous Disseminate</td>
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<td>Malignant Tumor (If treated/occurred within previous five years)</td>
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<td>Metastatic Cancer</td>
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<td>Motor or Sensory Aphasia</td>
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<td>Multiple or Disseminated Sclerosis</td>
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<td>Muscular Atrophy or Dystrophy</td>
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<td>Myasthenia Gravis</td>
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<td>Myotonia</td>
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<td>Open Heart Surgery</td>
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<td>Organ Transplant</td>
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<td>Paraplegia or Quadriplegia</td>
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<td>Parkinson’s Disease</td>
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<tr>
<td>Peripheral Arteriosclerosis (If treated within previous three years)</td>
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<td>Polycystic Kidney</td>
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<td>Posterolateral Sclerosis</td>
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<td>Renal Failure</td>
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<td>Serious Mental Illness – refer to the Serious Mental Illness (SMI) Criteria Checklist effective July 27, 2010 (or subsequent replacement version)</td>
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<td>Sickle Cell Anemia</td>
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<td>Splenic Anemia (True Banti’s Syndrome)</td>
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<td>Still’s Disease</td>
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<td>Stroke (CVA)</td>
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<td>Syringomyelia</td>
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<td>Tabes Dorsalis (Locomotor Ataxia)</td>
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<td>Terminal illness requiring hospice care</td>
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<td>Thalessemia (Cooley’s or Mediterranean Anemia)</td>
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<td>Topectomy and Lobotomy</td>
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<td>Wilson’s Disease</td>
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</table>
13.C: Chronic Substance Use Disorder (SUD) Criteria Checklist

<table>
<thead>
<tr>
<th>SUD Criteria</th>
<th>DSM-V ICD-9</th>
<th>DSM-V ICD-10</th>
<th>Description</th>
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<tbody>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>292.9</td>
<td>F12.99</td>
<td>Unspecified Cannabis Abuse Disorder</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>303.90</td>
<td>F10.20</td>
<td>Alcohol Use Disorder – Moderate, Severe</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.00</td>
<td>F11.20</td>
<td>Opioid-Related Disorders – Moderate, Severe</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.20</td>
<td>F14.20</td>
<td>Stimulant-Related Disorder - Cocaine</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.30</td>
<td>F12.20</td>
<td>Cannabis- Related Disorder - Moderate, Severe</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.40</td>
<td>F15.20</td>
<td>Stimulant-Related Disorder – Other or unspecified stimulant</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.50</td>
<td>F16.20</td>
<td>Hallucinogen-Related Disorder- Other Hallucinogen Use</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.60</td>
<td>F16.20</td>
<td>Hallucinogen-Related Disorder – Phencyclidine Use Disorder –</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.90</td>
<td>F19.20</td>
<td>Other (or Unknown)Substance-Related and Addictive Disorders</td>
</tr>
</tbody>
</table>

Sources: *SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document, and Desk Reference to the Diagnostic Criteria from DSM-5.*

HSD - March 2016
13.D: Serious Medical Illness (SMI) Criteria Checklist

Serious Mental Illness (SMI) determination is based on the age of the individual, functional impairment, duration of the disorder and the diagnosis. Adults must meet all of the following four criteria:

1. **Age:** Must be an adult 18 years of age or older.

2. **Diagnoses:** Have one of the diagnoses as defined under the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.
   - Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

4. **Duration:**
   - The disability must be expected to persist for six months or longer.

Person must meet SMI criteria and at least one of the following in A or B:

- **A. Symptom Severity and Other Risk Factors**
  - Significant current danger to self or others or presence of active symptoms of a SMI.
  - Three or more emergency room visits or at least one psychiatric hospitalization within the last year.
  - Individuals with substance use disorder that complicates SMI and results in worsened intoxicated/withdrawal complications, bio medical conditions,
emotional/behavior/cognitive conditions.
☐ Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

☐ B. Co-Occurring Disorders

☐ Substance Use Disorder (SUD) diagnosis and any mental illness that affects functionality.
☐ SMI or SUD and potentially life-threatening chronic medical condition (e.g., diabetes, HIV/AIDS, hepatitis).
☐ SMI or SUD and Developmental Disability.

**Serious Mental Illness (SMI) – Severe Emotional Disturbance (SED) Criteria**

<table>
<thead>
<tr>
<th>SMI-SED Category</th>
<th>DSM-V ICD-9</th>
<th>DSM-V ICD-10</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>299.00</td>
<td>F84.0</td>
<td>Autism Spectrum Disorder</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>307.22</td>
<td>F95.1</td>
<td>Motor Disorder – Persistent (chronic) Motor or Vocal Tic</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>307.23</td>
<td>F95.2</td>
<td>Tourette’s Disorder</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>307.3</td>
<td>F98.4</td>
<td>Stereotypic Movement Disorder</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>314.00</td>
<td>F90.0</td>
<td>Attention –Deficit/Hyperactivity Disorder: Predominantly</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>314.01</td>
<td>F90.1</td>
<td>Attention –Deficit/Hyperactivity Disorder: Predominantly</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>314.01</td>
<td>F90.2</td>
<td>Attention –Deficit/Hyperactivity Disorder: Combined</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>314.01</td>
<td>F90.8</td>
<td>Attention –Deficit/Hyperactivity Disorder: Other Specified</td>
</tr>
<tr>
<td>Neurodevelopmental Disorders</td>
<td>314.01</td>
<td>F90.0</td>
<td>Attention –Deficit/Hyperactivity Disorder: Unidentified</td>
</tr>
<tr>
<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>293.81</td>
<td>F06.2</td>
<td>With delusions</td>
</tr>
<tr>
<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>293.82</td>
<td>F06.0</td>
<td>With hallucinations</td>
</tr>
<tr>
<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>295.40</td>
<td>F20.81</td>
<td>Schizophreniform Disorder</td>
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<tr>
<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>295.70</td>
<td>F25.0</td>
<td>Bipolar type</td>
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<tr>
<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
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<td>F25.1</td>
<td>Depressive type</td>
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<tr>
<td>SMI-SED Category</td>
<td>DSM-V ICD-9</td>
<td>DSM-V ICD-10</td>
<td>Description</td>
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<td>Schizophrenia</td>
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<td>F22</td>
<td>Delusional Disorder</td>
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<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>298.8</td>
<td>F28</td>
<td>Other Specified Schizophrenia Spectrum and Other Psychotic</td>
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<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
<td>293.89</td>
<td>F06.01</td>
<td>Catatonia Associated with Another Mental Disorder or</td>
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<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
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<td>Unspecified Schizophrenia Spectrum and Other Psychotic</td>
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<td>Schizophrenia Spectrum and other Psychotic Disorders</td>
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<td>F21</td>
<td>Schizotypal (Personality) Disorder</td>
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<td>F06.33</td>
<td>Bipolar and Related Disorders due to another medical condition. Specify:</td>
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<tr>
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<td>Bipolar and Related Disorders due to another medical condition</td>
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<td>F31.12</td>
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<td>With psychotic features</td>
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<td>296.45</td>
<td>F31.73</td>
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<td>296.46</td>
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<td>F06.31</td>
<td>Bipolar and Related Disorders Due to Another Medical Condition</td>
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<td>F06.32</td>
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<td>Obsessive-Compulsive Related Disorders</td>
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<td>F42</td>
<td>Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified Obsessive-Compulsive</td>
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<td>F45.22</td>
<td>Body Dysmorphic Disorder</td>
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<td>Obsessive-Compulsive Related Disorders</td>
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<td>F63.3</td>
<td>Trichotillomania (Hair-Pulling Disorder)</td>
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<td>Obsessive-Compulsive Related Disorders</td>
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<td>L98.1</td>
<td>Excoriation (Skin-Picking) Disorder</td>
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<td>Trauma-and Stressor Related Disorders</td>
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<td>Acute Stress Disorder</td>
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<td>Trauma-and Stressor Related Disorders</td>
<td>309.0</td>
<td>F43.21</td>
<td>With depressed mood</td>
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<td>Trauma-and Stressor Related Disorders</td>
<td>309.24</td>
<td>F43.22</td>
<td>With anxiety</td>
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<td>Trauma-and Stressor Related Disorders</td>
<td>309.28</td>
<td>F43.23</td>
<td>With anxiety and depressed mood</td>
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<td>Trauma-and Stressor Related Disorders</td>
<td>309.3</td>
<td>F43.24</td>
<td>With disturbance of conduct</td>
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<td>Trauma-and Stressor Related Disorders</td>
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<td>F43.25</td>
<td>With mixed disturbance of emotions and</td>
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<td>Trauma-and Stressor Related Disorders</td>
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<td>F43.10</td>
<td>Posttraumatic Stress Disorder</td>
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<td>Trauma-and Stressor Related Disorders</td>
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<td>F43.8</td>
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<tr>
<td>Trauma-and Stressor Related Disorders</td>
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<td>F43.9</td>
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<td>F94.1</td>
<td>Trauma- and Stressor-Related</td>
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<td>Dissociative Amnesia</td>
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<td>F44.6</td>
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<tr>
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<td>F44.7</td>
<td>Conversation Disorder (Functional Neurological Symptom)</td>
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<td>F68.10</td>
<td>Factitious Disorder Imposed on Self, Factitious Disorder Imposed</td>
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<td>Somatic Symptom and Related Disorders</td>
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<td>F45.21</td>
<td>Illness Anxiety Disorder</td>
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<td>F45.1</td>
<td>Somatic Symptom Disorder</td>
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<td>F45.8</td>
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<tr>
<td>Feeding and Eating Disorders</td>
<td>307.1</td>
<td>F50.01</td>
<td>Anorexia Nervosa - Restricting type</td>
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<td>307.1</td>
<td>F50.02</td>
<td>Anorexia Nervosa– Binge-eating/Purging</td>
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<td>F50.9</td>
<td>Unspecified Feeding and Eating Disorders</td>
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<tr>
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<td>307.51</td>
<td>F50.2</td>
<td>Bulimia Nervosa (F50.2)</td>
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<td>F50.8</td>
<td>Binge-eating Disorder (F50.)</td>
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<tr>
<td>Feeding and Eating Disorders</td>
<td>307.52</td>
<td>F98.3</td>
<td>In children</td>
</tr>
<tr>
<td>Feeding and Eating Disorders</td>
<td>307.52</td>
<td>F50.8</td>
<td>In adults</td>
</tr>
<tr>
<td>Disruptive, Impulse Control and Conduct</td>
<td>312.33</td>
<td>F63.1</td>
<td>Pyromania</td>
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<tr>
<td>Disruptive, Impulse Control and Conduct</td>
<td>312.34</td>
<td>F63.81</td>
<td>Intermittent Explosive Disorder</td>
</tr>
<tr>
<td>Disruptive, Impulse Control and Conduct</td>
<td>312.81</td>
<td>F91.1</td>
<td>Childhood-onset type</td>
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<td>F91.8</td>
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<tr>
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<td>F91.3</td>
<td>Oppositional Defiant Disorder – Specify current severity: Mild,</td>
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<tr>
<td>Cyclothymic Disorder</td>
<td>301.13</td>
<td>F34.0</td>
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<tr>
<td>Persistent Depressive Disorder</td>
<td>300.4</td>
<td>F34.1</td>
<td>Persistent Depressive Disorder - Dysthymia</td>
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<tr>
<td>Personality Disorders [For which there is an evidence based clinical intervention available]</td>
<td>301.83</td>
<td>F60.3</td>
<td>Borderline Personality Disorder</td>
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Dissociative Disorders 300.13  F44.1  With dissociative fugue
Dissociative Disorders 300.14  F44.81  Dissociative Identity Disorder
Dissociative Disorders 300.15  F44.89  Other Specified Dissociative Disorder
Dissociative Disorders 300.15  F44.9  Unspecified Dissociative Disorder
Dissociative Disorders 300.6  F48.1  Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders 300.11  F44.4  Conversation Disorder (Functional Neurological Symptom Disorder. Specify:with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders 300.11  F44.5  Conversation Disorder (Functional Neurological Symptom)Disorder. Specify:With ith ith attacks of seizures; or with special sensory
<table>
<thead>
<tr>
<th>SUD Criteria</th>
<th>DSM-V ICD-9</th>
<th>DSM-V ICD-10</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>292.9</td>
<td>F12.99</td>
<td>Unspecified Cannabis Abuse Disorder</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>303.90</td>
<td>F10.20</td>
<td>Alcohol Use Disorder – Moderate, Severe</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.00</td>
<td>F11.20</td>
<td>Opioid-Related Disorders – Moderate, Severe</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.20</td>
<td>F14.20</td>
<td>Stimulant-Related Disorder - Cocaine</td>
</tr>
<tr>
<td>Substance-Related and Addictive Disorders</td>
<td>304.30</td>
<td>F12.20</td>
<td>Cannabis-Related Disorder - Moderate, Severe</td>
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<tr>
<td>Substance-Related and Addictive Disorders</td>
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<td>F15.20</td>
<td>Stimulant-Related Disorder – Other or</td>
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<td>Substance-Related and Addictive Disorders</td>
<td>304.40</td>
<td>F15.20</td>
<td>Stimulant-Related Disorder – Amphetamine-</td>
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<td>Substance-Related and Addictive Disorders</td>
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<td>F16.20</td>
<td>Hallucinogen-Related Disorder - Other</td>
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<td>Substance-Related and Addictive Disorders</td>
<td>304.60</td>
<td>F16.20</td>
<td>Hallucinogen-Related Disorder – Phencyclidine Use Disorder –</td>
</tr>
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<td>Substance-Related and Addictive Disorders</td>
<td>304.90</td>
<td>F19.20</td>
<td>Other (or Unknown)Substance-Related and Addictive Disorders - Moderate, Severe</td>
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</tbody>
</table>

Sources: SMI Criteria 8_19_2015 approved by the Collaborative document, SED Criteria 8_19_2015 approved by the Collaborative document, and Desk Reference to the Diagnostic Criteria from DSM-5.
HSD - March 2016

13.E: NF LOC Supplement
School-Based Health Centers (SBHCs) are comprehensive primary health care centers on or adjacent to school grounds that provide physical and behavioral health services to students and community members.

By offering a range of health care services in school settings, SBHCs simultaneously increase access to care and decrease the amount of classroom time missed by students leaving campus for care in traditional settings. As a result, SBHCs can positively impact academic participation as well as health outcomes.

SBHCs also promote positive health behaviors and healthcare literacy by increasing health knowledge and decision-making skills in the students they serve.

SBHCs play a role in achieving the Centennial Care goal of “Assuring that Medicaid recipients in the program receive the right amount of care at the right time and in the most cost effective or ‘right’ settings”. HSD/MAD contracts with the New Mexico Department of Health’s Office of School and Adolescent Health (DOH/OSAH) for the provision of funding, leadership, support and oversight to nearly 50 SBHCs across New Mexico.

New Mexico’s SBHCs are differentiated across three categories:

1. **DOH/OSAH Contract Status**- SBHCs may choose to contract through a sponsoring organization for funding and administrative support through the New Mexico Department of Health’s Office of School and Adolescent Health (DOH/OSAH);

2. **Sponsorship**- Through CY2017, SBHCs contracting with DOH/OSAH do so under either medical sponsorship (i.e. an FQHC or medical group) or non-medical sponsorship (i.e. an educational cooperative). A Sponsoring Entity provides its designated SBHC(s) one or more of the following: funding, staffing, medical oversight, liability insurance, and billing support; and

3. **Provider Type**- SBHCs may apply for approval for HSD/MAD Certification for Medicaid billing as either a Provider Type 321 (SBHC) or Provider Type 313 (FQHC).

4. A SBHC submitting a MAD 335 application as a Provider Type 313 must present a copy of documentation from CMS certifying the center or its sponsoring entity as an FQHC.
A DOH/OSAH-contracted SBHC submitting a MAD 335 application as a Provider Type 321 must present either (1) evidence of HSD/MAD certification for billing or (2) a letter of exemption from HSD/MAD.

HSD/MAD Certification is a positive determination of a SBHC’s administrative eligibility for enrollment for Medicaid billing. It is based upon evidence of licensure by appropriate regulatory agencies and adherence to the *New Mexico Standards and Benchmarks for School Based Health Clinics* (sic) (*Standards and Benchmarks*) as maintained by DOH/OSAH in collaboration with HSD/MAD. Certification is issued for a period of **three years** and is subject to revocation in the event that HSD/MAD becomes aware of loss of appropriate licensure(s) or significant deviation from the *Standards and Benchmarks*.

HSD/MAD shall be responsible for the initial certification of SBHCs enrolling as Provider Type 321 and for the recertification of all Provider Type 321s with non-medical sponsorship.

The MCOs shall be responsible for the recertification of all Provider Type 321s with medical sponsorship.

**CERTIFICATION PROCESS**

Initiation:

1. A DOH-contracted SBHC or its sponsoring entity may petition for HSD/MAD certification any time after the finalization of its contract with DOH/OSAH and receipt of the *Standards and Benchmarks*.
2. Requests shall be made in writing to HSD/MAD’s Centennial Care Contracts Bureau. (Electronic communications shall be acceptable.)
3. Within ten business days of the receipt of a request for SBHC site certification, a representative of HSD/MAD will specify in writing to both the DOH-contracted SBHC and its sponsoring entity a deadline for the submission of all documentation required for certification. Unless to accommodate a request made by the applicant site, this deadline shall not be less than four weeks from the date upon which notification is sent.

**PACKET SUBMISSION**

The applicant site and sponsoring entity shall submit:

1. A hard or electronic copy of an acknowledgement of receipt and attestation of adherence to *Standards and Benchmarks*, signed by the CEO of the sponsoring entity and the SBHC administrator; and a completed SBHC Site Review Self-Assessment, signed by the CEO of the sponsoring entity and the SBHC administrator.
2. A hard or electronic copies of:
   A. The latest fire inspection report by the fire authority having jurisdiction over the site;
   B. Health certificates of all staff;
   C. Current license, registration or certificate of each staff member for which a license, registration, or certification is required by the State of New Mexico;
   D. Valid drug permit from the New Mexico Board of Pharmacy;
   E. Current Clinical Laboratory Improvement Amendments (CLIA) certificate; and
   F. Evidence of other licensure and/or certification by appropriate jurisdictional agencies as requested.

3. A hard or electronic copies of each of the following:
   A. The SBHC’s Policy and Procedure Manual, which shall include at a minimum the policies and procedures described in the Standards and Benchmarks; and
   B. Staff training logs, complaint logs, facility licenses, Material Safety Data Sheets (MSDS), pharmacy logs, laboratory logs, and other materials that may be specified by the Site Review Team.

4. Photographs or videos to provide evidence of compliance with such standards as the requirement for “No Smoking” signs, “Handicap Accessibility” signs, and the posting of appropriate licenses.

**SITE REVIEW**

A Site Review Team comprised of at least one member of HSD/MAD and one member of DOH/OSAH shall:

1. Convene to review the SBHC’s submissions within 10 business days after the deadline for receipt.
2. Conduct a telephone or video interview with the SBHC staff and sponsor to discuss findings, questions, concerns, and recommendations.
3. HSD/MAD will issue a letter to the SBHCs, Sponsor, DOH/OSAH, and the MCOs within 10-15 business days after completion of site review indicating whether the SBHC has passed or failed the review.
   A. If the SBHC/Sponsor passed, the HSD/MAD letter will include the effective date the SBHC and Sponsor are eligible to begin billing Medicaid.
   B. If the SBHC/Sponsor failed, the HSD/MAD letter will include the reasons and requirements the SBHC must complete to pass the certification/recertification process. If the SBHC/Sponsor is not able to correct the noted deficiencies within 10 business days from receipt of letter, HSD/MAD will send notification to the SBHC/Sponsor requesting a Corrective Action Plan (CAP).
      a. The CAP must address each noted deficiency, action steps required to correct the deficiency, and the desired outcome with a due date.
b. The SBHC/Sponsor will have 60 calendar days upon receipt of the notification to implement the CAP and correct all deficiencies. Evidence of the corrections must be submitted to HSD/MAD before or on the 60th day.
c. HSD/MAD will determine what documentation in what form is required based on the CAP and resolution of deficiencies.
d. HSD/MAD will send a letter of certification/recertification to the SBHC, Sponsor, DOH/OSAH, and the MCOs within 5 business days of resolution of deficiencies and completion of the CAP,
e. If the CAP is not completed and deficiencies are not resolved, HSD/MAD will collaborate with DOH/OSAH to determine if certification/recertification is possible and next steps.

RECERTIFICATION PROCESS

For Provider Type 321s with Non-Medical Sponsorship:

HSD/MAD shall be responsible for the recertification of DOH-funded SBHCs sponsored by non-medical entities.

1. The recertification site review will be conducted by the HSD/MAD Site Review Team no later than six weeks before the expiration of current certification.
2. HSD/MAD will schedule the site review through the SBHC’s Sponsoring Entity.
3. HSD/MAD shall ensure that the Sponsoring Entity has access to the most recent copy of the Standards and Benchmarks, SBHC Site Review Self-Assessment, and the Site Review Guide within one month of the site review.
4. The site review will be conducted as outlined in Certification Process above.

For Provider Types 321 with Medical Sponsorship:

The MCOs shall be responsible for the recertification of DOH-funded SBHCs sponsored by medical entities.

1. "In January of each year, no later than the first quarterly meeting of the MCO SBHC Advisory Committee, HSD/MAD will provide the MCOs with a list of medically-sponsored DOH/OSAH contracted SBHCs with expiring certifications, including recertification due date, and the MCO responsible for performing the site review.
2. The designated MCO will conduct the site review no later than six weeks before the expiration of current certification.
3. The MCO will schedule the site review with the Medical Sponsor. The review may be conducted remotely. There is no requirement for a site visit.
4. The MCO shall ensure that the Medical Sponsor has access to the most recent copy of the Standards and Benchmarks, SBHC Site Review Self-Assessment, and the Site Review Guide within one month of the site review.

5. The designated MCO shall instruct the Medical Sponsor and SBHC to make available hard or electronic copies of:
   a. SBHC Policy and Procedure Manual, including the policies and procedures described in the Standards and Benchmarks and the SBHC Site Review Self-Assessment,
   b. Staff training logs, complaint logs, personnel files, facility licenses, Material Safety Data Sheets (MSDS), pharmacy logs, laboratory logs, and requested medical records, and
   c. Copies of licensure by jurisdictional agencies including The New Mexico Board of Pharmacy;
   d. Any other documentation as deemed necessary after consult with HSD/MAD; and
   e. The completed SBHC Site Review Self-Assessment.

6. The SBHC may use photographs or audiovisuals to provide evidence that the clinics have required items such as “No Smoking” signs, “Handicap Accessibility” signs, or possession of appropriate licenses.

7. The designated MCO review team shall:
   a. Meet with the clinic staff and sponsor representatives in person, by phone or by video conference to discuss the site review process,
   b. Review the completed SBHC Site Review Self-Assessment,
   c. Use the HSD/MAD electronic Assessment Tool to determine adherence to the SBHC Standards and Benchmarks, and
   d. Conduct an exit interview with the staff and sponsor to discuss findings, questions, concerns, and recommendations. A verbal indication will be given of the certification status.

8. The MCO will deliver the site review documentation to HSD/MAD within ten (10) business days. HSD/MAD will compile the data and make the final determination for recertification.

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.”

MCO RESPONSIBILITY

1. The HSD and MCOs contracts 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.
3. 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.
4. SBHCs should not bill private payors for services rendered to an adolescent who, according to state law, consented to receive them without parental knowledge.
5. The MCOs are to suspend the distribution of Explanation of Benefits (EOBs) for all confidential services provided at SBHCs.
15 I/T/U RELATED

Revision dates: August 15, 2014
Effective date: January 1, 2014

1. FQHC/Tribal 638 Claims Processing (Alamo and Pine Hill)

2. 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.

3. 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.

4. 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.

5. 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.
ADMINISTRATIVE HEARINGS

Reference: 8.308.15 NMAC Grievances and Appeals

Under managed care rules, the Managed Care Organization (MCO) must have a grievance process and an appeal process for members as described in the above rule. The MCO must be familiar with the provisions of the rule and have procedures in place that follow the rule.

All rules and requirements related to the appeal and hearing processes must be followed from the initial adverse determination, which would typically either be the denial or reduction of a requested service or level of care, or the discontinuation or reduction of an existing service or level of care.

Time limits requiring advance notice prior to the MCO taking an adverse action against a member’s existing service or level of care, (including actions by a member’s receiving MCO that did not authorize the original service) are all important and must be followed. It is from that initial adverse action, and the adverse action that a receiving MCO may take, that all the remaining provisions of the notification, rights to continuation of a benefit, MCO appeal, and HSD administrative hearing process may follow. Therefore, all notices to the member must accurately advise the member of his or her appeal rights, and all notices must adhere to the time frames specified in the rule.

Grievances: The grievance process should not be confused with the appeal and administrative hearing processes. The appeal process can eventually lead to a HSD administrative hearing before the HSD Fair Hearings Bureau (FHB). The grievance process is an internal resolution process within the MCO. It must always be made clear to the member when to file an appeal rather than to file a grievance. A member can file an appeal if unsatisfied with the outcome of the grievance process when the member is still within the time requirement for filing an appeal. Filing a grievance in no way alters or extends the time that the member has to file an appeal.

Provider Appeal:
The provider appeal process is included in the above rule. This process exists only within the member’s MCO. While HSD does have a provider hearing process for some fee-for-service provider issues, the MCO provider appeal process does not lead to a HSD administrative hearing before FHB.
Member Appeal:
The member MCO appeal process is included in the above rule. The member MCO appeal process can eventually lead to a HSD administrative hearing before the FHB.

The MCO must assure that the member is informed of all rights regarding the right to an appeal and the MCO appeal process, and as applicable, a HSD administrative hearing process. Time limit requirements are stated in the rule for both the MCO and the member. The MCO must follow all of the requirements of the rule related to the MCO appeal process.

A member must file a MCO appeal with his or her MCO within 90 calendar days of the receiving a notice of the intent of the MCO to take an adverse action regarding the member’s services.

A member has 10 calendar days (unless permitted in another New Mexico Administrative Code (NMAC) applicable rule) to request a continuation of his or her benefit during the MCO appeal process. The continuation of a benefit is only available to a member that is currently receiving the benefit under appeal. The continuation of the benefit will be the same as the member’s current service, allocation, budget or LOC.

When the member has exhausted his or her MCO appeal process, and if the member acts within the time frame specified in 8.308.14 NMAC and 8.352.2 NMAC, the member has the right to file a request for a HSD administrative hearing with the FHB. Within HSD, the terms Administrative Hearing and Fair Hearing mean the same thing.

Members can request a HSD administrative hearing with the FHB in writing or orally. The HSD administrative hearing must be requested within 30 calendar days of the MCO’s notice of the final appeal decision.

THE MEMBER’S HSD ADMINISTRATIVE HEARING:

Reference: 8.352.2 NMAC Claimant Hearings

Once a member’s request for a HSD administrative hearing has been received by FHB, and if the member was approved for a continuation of his or her benefit during the MCO appeal process, the member’s continuation of the benefit remains in place until a HSD administrative hearing final decision is rendered.

Once a member notifies FHB, FHB acknowledges receipt of the request to the member and notifies the MAD Administrative Hearing Unit (MAD AHU) and the MCO in writing of the request with relevant information about the member, including the member’s self-identified issues. MAD AHU maintains a log of all HSD administrative hearing requests. Once the FHB assigns an administrative
law judge (ALJ), the ALJ will send out a scheduling notice of the HSD administrative hearing date, time and call in number to all parties. Parties to the hearing may include legal counsel or other authorized representatives. Unless an accommodation is requested and approved by the ALJ, all HSD administrative hearings are conducted telephonically. The assigned ALJ is responsible for the oversight of the HSD administrative hearing process including conducting the actual hearing.

The MCO may invite the member to an informal conference to clarify or define the issues prior to the HSD administrative hearing and if possible, reach a mutually agreed upon decision. The member is not required to participate in a MCO informal conference.

The formal rules of evidence and civil procedure do not apply to the HSD administrative hearing proceedings. Relevant evidence is submitted into the hearing record and testimony is furnished during the proceedings in an orderly but less formal manner. However, the record created for the HSD administrative hearing is a legal document and is the record which forms the basis for decisions made by a New Mexico district court if the member should seek redress after his or her HSD administrative hearing final decision has been rendered. The evidence and testimony entered into the hearing record forms the official HSD record and only information contained within the hearing record can be admitted into evidence in a New Mexico district court appeal; HSD, the member or the MCO cannot add to or delete from this hearing record after the close of the actual HSD administrative hearing. The State district court is allowed to set aside the HSD administrative final decision only if it finds the decision to be arbitrary, capricious or an abuse of discretion, not supported by substantial evidence in the hearing record as a whole, or otherwise not in accordance with the law.

Once a member receives a MCO appeal final decision and the member elects to request a HSD administrative hearing, the member and MCO are governed by the New Mexico Administrative Code (NMAC) 8.352.2 rule. The process that the member and MCO are to follow for a HSD administrative hearing is detailed in this rule.

Summary of Evidence
Prior to the HSD administrative hearing, the MAD AHU must submit a summary of evidence (SOE) that includes relevant demographic information, summary of issues, clinical and administrative documentation, correspondence, etc. MAD will be responsible for completing the member demographic section of the summary and developing the summary of issues. The MCO will be responsible for submitting to MAD AHU (in a timely manner that allows MAD AHU to prepare a comprehensive SOE), all documentation (clinical and administrative) concerning how and why the MCO’s initial adverse action decision was made and the grounds used by MCO to uphold the appealed decision. MAD AHU must deliver to the assigned ALJ and all other parties to the HSD administrative hearing its SOE at least 10 working days prior to the HSD administrative hearing.
Final Decision
At the conclusion of the HSD administrative hearing, the ALJ prepares a summary of facts and his or her recommendation and submits this and the entire hearing record to MAD AHU. The record of the HSD administrative hearing is reviewed by the Director of MAD or his or her designee and the final decision rests with the Director or his or her designee. Under federal law, the entire HSD administrative process must be completed within 90 calendar days of the date that the member requested a HSD administrative hearing. The member and other parties to the hearing are provided with the HSD administrative hearing final decision.

The member has 30 calendar days to file an appeal of the HSD administrative hearing final decision with the appropriate New Mexico district court. The filing of a notice of appeal shall not stay the enforcement of the HSD administrative hearing final decision. The member may seek a stay upon a motion to the court or the member may request the MAD director or designee to stay the HSD administrative hearing final decision while the adverse action is on appeal in a New Mexico district court. If the Court orders a stay, the MCO will maintain the benefit at issue in accordance with the State district court’s order. If the New Mexico district court’s final decision is in favor of HSD and the member continued utilizing his or her benefit during the district court appeal process, see 8.352.2.19 NMAC for the repayment process.

Important Aspects of the Process

One of HSD’s primary goals related to its administrative hearings is to have all MCOs implement procedures that are consistent with its NMAC MAD rules and that will be practiced and adhered to by all parties involved. The following are focus points for process improvement:

1. Timeliness in all phases of the process;
2. Maintain member confidentiality and protect PHI information;
3. Emphasize maintenance of complete and organized files;
4. Emphasize importance of documentation; and
5. Accountability.

The MCOs are key players in this process. Therefore, MCO participation to assist with the process is required. As part of this initiative, and in order to maintain organized and complete files, HSD is requesting that all MCOs use a standardized HSD SOE form. Each SOE shall contain four (4) separate titled sections. The MCO is to provide the information listed on each titled section of the SOE to MAD AHU in a timely manner so it may meet HSD administrative hearing and CFR requirements.

Special Situations:
There have been questions related to whether both the relinquishing and receiving MCOs are to respond to their members’ appeals and participate in the HSD administrative hearing when a member is transitioning from one MCO to another.

Each MCO is responsible for its own process while still following the instructions for continuation of benefits for the initial 30 days after transfer, regarding the member’s right to request a MCO appeal and for a continuation of his or her benefits.

Questions and Answers:

1. **If a member requests a MCO appeal or a HSD administrative hearing for a service that has not been provided, and it is found that they will be transferring to another MCO while the member’s MCO appeal process or his or her HSD administrative hearing is underway, how should we proceed?**

**RESPONSE:**

For a requested benefit that has not been provided:

A. The relinquishing MCO must still complete the MCO appeals process even if the appeal decision or HSD administrative hearing takes place after the member has transferred. However, if the decision comes after the member has transferred, it may be reasonable for the MCO’s final appeal decision to be that the member is no longer enrolled in the MCO so the service cannot be provided through the relinquishing MCO. Even then, the member may appeal the decision to HSD, but likely the finding would be the same.

B. The member needs to file a new request for services with the receiving MCO because that will be the MCO responsible for providing the service. If the receiving MCO denies the service, then a new appeal process begins with the receiving MCO.

C. However, if a member is still in the MCO when the decision is made, the MCO decision must be based on the information provided during the MCO appeal process; and not denied on the basis that member will be transitioning to a new “receiving” MCO soon.

For an existing benefit which is being provided subject to a continuation of benefit request:

A. The relinquishing MCO must still complete the MCO appeals process even if the appeal decision or HSD administrative hearing takes place after the member has transferred. This is essential because a final determination must be made to determine if the member is responsible for payment for services that were
“continued” under the relinquishing MCO for the time period the member was enrolled with the relinquishing MCO.

When the relinquishing MCO makes a final decision on the member’s appeal, or when the HSD administrative hearing final decision is rendered, it is applicable only for the time period that the member was enrolled in the relinquishing MCO.

Because a receiving MCO issues its own notice of adverse action concerning the same benefit, the receiving MCO’s appeal process and possible subsequent HSD administrative hearing is applicable only for the time period that the member is in the receiving MCO. Therefore, it is possible that there may be concurrent appeals and administrative hearings for the same member for the same benefit but for different time periods. The different time periods correspond to the relevant dates that the member was enrolled in each MCO.

2. What happens in the case when the receiving MCO does not agree with the relinquishing MCO’s decision?

RESPONSE: If the relinquishing MCO makes a decision for a benefit for a time period that the member is still enrolled in the relinquishing MCO, the receiving MCO must accept that as the benefit the member has in place at the time of the transfer to the receiving MCO. The service must initially be continued through the receiving MCO under the transition of care provisions. The receiving MCO can notify the member of its intent to take an adverse action against the member’s benefit provided it is given 10 calendar days prior to ending the service (Notice of Action). See 8.308.11 NMAC Transition of Care for specific services that may allow for other considerations.

However, the receiving MCO must initially continue to provide the relinquishing MCO’s approved benefit. The member and the receiving MCO essentially begin the process of notice and right to appeal again. The receiving MCO must follow the same process with regard to time and notice. The receiving MCO would notify the member of its intent to take an adverse action concerning the member’s existing benefit, LOC, or service within 10 calendar days prior to the date of the intended adverse action. The member must file a new appeal request with the receiving MCO. The member has the right to make a new request for a continuation of the benefit from the receiving MCO and must do so in order for the benefit to continue during an appeal process. The member’s request for a continuation of benefits to the relinquishing MCO does not carry over to the receiving MCO. This process must be made clear to the member.

We want to emphasize that the contract provision for the 30 calendar day coverage of the member’s benefit by the receiving MCO is an HSD contract requirement, but it does not replace the responsibility of the MCO to follow federal and state laws, statues, regulations
and rules for member notification when it intends to take an adverse action against the
member, the member’s right to appeal, and the right for continuation of the member’s
benefit.

3. How will each MCO’s Medical Director fit into the scenario? Are they going to have to
work with the new MCO to handle a re-review if there is a disagreement?

RESPONSE: See above answer. Each MCO handles the issue separately.

4. Will the member need to know this is going on and who would be responsible to let the
member know this is occurring?

RESPONSE: The member does need to be informed. The member is entitled to a notice of
adverse action from the receiving MCO, just like he or she received from the relinquishing
MCO. The communication to the member must be clear about the need to file a new MCO
appeal request and make a new request to his or her receiving MCO for a continuation of his
or her benefit during the MCO appeal process.

5. Is the current MCO’s decision binding regardless of the other MCO’s opinion?

RESPONSE: The only sense in which it is “binding” is that if a benefit was provided by the
relinquishing MCO, even if that benefit was provided through an appeal of administrative
hearing process, then that member is considered to have that benefit at the time of transfer to
the receiving MCO. As for any benefit which the member is receiving when he or she
transfers into a receiving MCO, the receiving MCO must initially provide the benefit, but it
is subject to a new notice of adverse action or re-authorization.

6. Will each receiving and relinquishing MCO need to continue to do this process anytime
a member changes MCO?

RESPONSE: Yes, in the sense that when a member is transitioning to another MCO, and the
receiving MCO is intending to take an adverse action affecting a benefit against a member
(that is, discontinue or reduce the existing service.) But the relinquishing and receiving
MCOs each make their decisions separately for the time period that the member is in their
MCO. However, the receiving MCO still has the responsibility for new notification of its
intent to take an adverse action against the member.

7. How will each MCO’s Appeal Unit be notified when a member has changed MCO?

RESPONSE: The relinquishing MCO would know when the member leaves. Its appeal unit
should review the enrollment status of the members that have an on-going appeal on a
monthly basis.
The receiving MCO knows when it receives a transitioning new member. When a provider is rendering an existing benefit approved by the relinquishing MCO, and that benefit requires authorization or a LOC, a provider may need to report when requesting an authorization to the receiving MCO that the member has already been receiving the benefit. The notification that goes to a member upon denying an existing benefit is significantly different from the notice that denies a new benefit. The receiving MCO’s member services unit may be the first to learn about this issue by receiving a call from a member. Several receiving MCO units would likely be aware of its transitioning member’s rights through the relinquishing MCO to request a continuation of his or her benefit and of the member’s request for a MCO appeal of the adverse action, as well as which benefits the relinquishing MCO is covering under a continuation of benefits.

Note that when a member requests a MCO appeal and is approved for the continuation of his or her benefit by the relinquishing MCO, the continuation of the benefit does not transfer to the receiving MCO. The receiving MCO must furnish that benefit for 30 calendar days. The receiving MCO will determine if it will take an adverse action against the member concerning this benefit and proper notice must be provided to the member in applicable MCO notification.

When a member requests a HSD administrative hearing following his or her MCO appeal final decision that upholds the MCO’s adverse action, and there is a continuation of the member’s benefit in place, the member’s continuation of his or her benefit will still be in effect until a HSD administrative hearing final decision is rendered. The member does NOT have to file an additional request for the continuation of his or her benefit with HSD. The benefit continues through his or her HSD administrative hearing process as it was originally requested at the time of the MCO appeal.
17 MANAGED CARE REPORTING

Revision dates: August 15, 2014; February 23, 2015, March 1, 2017

Effective date: January 1, 2014

Managed Care Organizations (MCOs) are required to comply with all reporting requirements established by HSD as specified in the State’s Medicaid Managed Care Agreement, which details requirements for timely submission, formatting, completeness and accuracy of content. MCOs are provided with State-approved instructions and templates to facilitate timely, complete, and accurate reporting. A complete list of current reports is incorporated in this Manual as 17.A: Centennial Care MCO Reports.

GENERAL REQUIREMENTS

HSD, at its discretion, may request information and/or data, identified as ad hoc requests. Ad hoc requests are issued to the MCOs for various reasons and information is generally requested to address a separate and distinct issue or to provide clarification on issues that fall outside the scope of reporting, i.e., provider information, claims research, nursing facility census, etc.

MCOs are required to implement continuous improvement processes to identify instances and patterns of non-compliance. Identified patterns of non-compliance are addressed internally by MCOs to improve overall performance and compliance.

At its discretion, HSD may, at any time, revise existing report content. HSD may seek MCO input. Beginning the day HSD issues finalized Report Instructions and Templates, MCOs will have at least (14) calendar days, and additional time at HSD’s discretion, to implement report content changes depending on the nature of the changes.

MCO REPORTING & INTAKE

HSD’s report management process involves the following:

1. Downloading MCO report submissions via Xerox secure File Transfer Protocol (FTP) site;
2. Processing MCO report submissions, resubmissions and other related documents;
3. Acknowledging receipt of reports within forty-five (45) calendar days of receipt of the report upload date;
4. Performing an initial quality check to ensure the MCO report is timely, accurate, complete, formatted correctly, submitted on the correct template version and is accompanied by a signed and dated Attestation;
5. Recording all report review information and actions into a MCO Reports Tracking Tool;
6. Assigning MCO reports to Subject Matter Experts (SMEs) who possess the knowledge and experience to conduct a thorough analysis of MCO reports and verify MCO compliance with HSD requirements and performance standards;
7. Tracking and monitoring the MCO report review and data analysis process;
8. Managing HSD Report Reviewer and Contract Manager (CM) timeframes for MCO report finalization; and
9. Uploading HSD feedback (Acceptance, Rejection, Final Review Tool etc.) to the FTP site.

**REPORT REJECTION**

An MCO Report may be rejected, by HSD, due to the following reason(s):

1. Report contains data inaccuracies
2. Report did not include a signed Attestation
3. Report was incomplete (e.g. data missing in fields)
4. Report was not formatted correctly
5. Report is not on the correct template
6. Report has incorrect naming convention
7. Report does not include a correct reporting period, MCO name and report run date

If any of the reasons above apply, the HSD Contract Manager will determine whether a Rejection is warranted, or if a Technical Assistance (TA) Call or other solution is preferred.

**MCO REPORT RESUBMISSION**

HSD has developed and implemented several processes (Technical Assistance Call, Self-Identified Error Resubmission) that continue improving the MCOs’ level of data accuracy and reporting compliance regarding report resubmissions.

**TA Call Process**

HSD Contract Managers are available to provide technical assistance to MCOs regarding the reporting process in the following areas:

1. HSD’s review and final feedback
2. Extension of report submission deadlines
3. Resolution of reporting concerns

In an effort to maximize and improve MCO reporting and data efficiency levels, HSD may conduct a TA call to address data-related questions and concerns. This process continues to create a window of opportunity for MCOs to gain valuable guidance from HSD Contract Managers and SMEs.

After a TA Call is held, the HSD Contract Manager determines whether the MCO’s report is Accepted or Rejected.

**Self-Identified Error Resubmission (SIER)**
In addition to Section 4.21.1.6 of the Agreement, MCOs must upload a SIER report within the deadline specified by an HSD Contract Manager.

MCOs are required to accurately label each subsequent report submission with the appropriate version number (v2, v3, v4).

HSD Contract Managers approve all MCO Report Rejections and SIERs; manage the TA Call process; and direct the overall resubmission of MCO reports.

HSD continues to evaluate its managed care reporting and resubmission processes to make certain they are effective, align with HSD policies and procedures and subsequently lead to positive MCO reporting outcomes.

**REPORT REVISIONS**

HSD conducts report revisions as necessary through a formal, written process in which MCOs and end users request needed changes to data reporting metrics. This process is intended to streamline managed care reporting and reduce administrative burden by limiting data collection, where possible, to meet federal and state requirements. Changes to HSD’s managed care data reporting also supports the needs of external agencies and stakeholders.

The report revision process begins with submission of a formal request to HSD. If the request is approved, the Centennial Care Contracts Bureau (CCCB) will organize a revision workgroup with SMEs and report reviewers to make required revisions or modifications.

When the workgroup completes this function, a draft reporting package is submitted to MCOs for comment and testing. Comments may be rejected or accepted, resulting in additional revisions to the reporting package. HSD then issues the final reporting package to MCOs for implementation.

**SYSTEM AVAILABILITY REPORTING**

MCOs must notify HSD of MCO’s and its subcontractor’s systems availability and performance. In the event of scheduled unavailability of critical Member and provider Internet and/or telephone-based functions and information, including but not limited to Member eligibility and enrollment systems, MCOs must notify HSD in advance via email at the following address HSD.MCOSystemsAvail@State.nm.us in order to obtain approval by HSD. In the event of an unforeseen and unscheduled inaccessibility of any critical systems, MCOs must notify HSD via email to the above address as soon as possible.

Furthermore, in the event of a problem with system availability that exceeds four (4) hours, MCOs are directed to notify HSD immediately via email at the following address HSD.MCOSystemsAvail@State.nm.us. MCOs are to provide HSD via generic email address, within five (5) business days, with full written documentation that includes a Corrective Action Plan describing how MCO will prevent the problem from occurring again.
In the event of any critical systems unavailability that has been already approved and agreed upon by HSD but the amount of downtime exceeds what was initially approved by HSD, MCOs must notify HSD immediately via email at the following address HSD.MCOSystemsAvail@state.nm.us.

During Federal and/or State Holidays and weekends, the same processes included above would apply.

For any critical Member or provider system unavailability, MCOs should also immediately contact Linda Gonzales, Medical Assistance Division, Systems Bureau Chief, at (505) 629-6278 and email her at linda.gonzales@state.nm.us.

For any email notification pertaining to the above direction, MCOs must use the HSD developed template included in this section as 17.B: Systems Availability Incident or Event Report.
# 17.A: Centennial Care MCO Reports

<table>
<thead>
<tr>
<th>Report No.</th>
<th>Report Title</th>
<th>Frequency</th>
<th>Report Objective</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Native American Members Report</td>
<td>Quarterly</td>
<td>To ensure Native American members have access to care and are receiving needed services.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Call Center Report - Monthly</td>
<td>Monthly</td>
<td>To capture call center statistics and ensure that callers can access a call center agent in a timely manner.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Network Adequacy Report</td>
<td>Quarterly</td>
<td>To monitor the MCO’s compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers and single-case agreements (SCAs).</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Self-Directed Report</td>
<td>Quarterly</td>
<td>To (i) monitor the amount of the annual self-directed community benefit budget used by members, (ii) identify the services that are highly utilized, (iii) identify members that have over-utilized or under-utilized their annual community benefit budget; and (iv) identify members whose cost of care in the community is greater than 80% of the cost of care in a private nursing facility.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Admissions and Readmissions Report</td>
<td>Quarterly</td>
<td>To monitor the number of members who are readmitted to a facility such as, an RTC, TFC, hospital, within thirty (30) calendar days of a previous discharge and to track follow-up appointments after discharge. This report ties to performance measure #8: Follow-up after Hospitalization for Mental Illness, from the Centennial Care contract.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Care Coordination Report</td>
<td>Quarterly</td>
<td>The Care Coordination report monitors assessments, ongoing care coordination activities, and changes of care coordination levels for all levels of care coordination.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Care Transitions Report</td>
<td>Quarterly</td>
<td>To monitor member assessments and transitions from nursing facilities to the community and to track the number of members readmitted to a nursing facility after transitioning to the community.</td>
<td></td>
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<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
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<tr>
<td>8</td>
<td>Level of Care (LOC) Report</td>
<td>Monthly</td>
<td>To capture data regarding the nursing facility (NF) Level of Care (LOC) determination process including timeframes, activities of daily living, and care settings.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>9</td>
<td>Agency-Based Community Benefit Report</td>
<td>Quarterly</td>
<td>To (i) monitor the number of members that changed to agency-based community benefit, (ii) identify the services used by members receiving agency-based community benefit, and (iii) identify members whose cost of care in the community is greater than 80% of the cost of care in a private nursing facility.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Caseload and Staffing Ratio Report</td>
<td>Monthly</td>
<td>To ensure an adequate number of care coordinators are available and that staffing ratios are sufficient to address member needs.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>11</td>
<td>Unreachable Members Report</td>
<td>Monthly</td>
<td>To capture information regarding efforts to contact members who are difficult to reach.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>12</td>
<td>Provider Satisfaction Survey Report</td>
<td>Annually</td>
<td>To review the results from the survey, including information regarding overall satisfaction (claims, provider relations, network, utilization and quality management, pharmacy and drug benefits, and continuity of care).</td>
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<tr>
<td>13</td>
<td>Call Center Report - Daily</td>
<td>Daily</td>
<td>To capture daily call center statistics and ensure that callers can access a call center agent in a timely manner.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>14</td>
<td>Call Center Report - Weekly</td>
<td>Weekly</td>
<td>To capture weekly call center statistics and ensure that callers can access a call center agent in a timely manner.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>15</td>
<td>Audited HEDIS Results</td>
<td>Annually</td>
<td>To monitor and review audited HEDIS results.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Encounter Processing and Submission Report</td>
<td>Monthly</td>
<td>To track encounters paid in a reporting period and to provide a cross tabulation of service delivery cost by month of service and month of payment for managed care encounters including all professional, institutional, dental and pharmacy encounters.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>Report No.</td>
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<tr>
<td>17</td>
<td>Member Care Coordination Activities Report</td>
<td>Quarterly</td>
<td>To monitor the MCO's UM Program Evaluation to monitor overall effectiveness, an overview of UM activities, and an assessment of the impact of the UM program on management and administrative activities. The MCO’s review and analysis shall be incorporated in the development of its following year’s UM Work Plan.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>18</td>
<td>UM Program Description, Associated Work Plan and Evaluation</td>
<td>Annually</td>
<td>To monitor the MCO's UM Program Evaluation to monitor overall effectiveness, an overview of UM activities, and an assessment of the impact of the UM program on management and administrative activities. The MCO’s review and analysis shall be incorporated in the development of its following year’s UM Work Plan.</td>
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<tr>
<td>19</td>
<td>UM Program Evaluation</td>
<td>Annually</td>
<td>To evaluate the overall effectiveness of UM including an overview of UM activities and an assessment of the impact of the UM program on management and administrative activities.</td>
<td>LOD #29: Combined with 18</td>
</tr>
<tr>
<td>20</td>
<td>Disease Management Description and Evaluation</td>
<td>Annually</td>
<td>To monitor and review the MCO's Disease Management program which includes a description of MCO activities regarding chronic conditions identified in the DM program description. DM is a component of care coordination and must include behavioral health as part of the program.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Disease Management Annual Evaluation</td>
<td>Annually</td>
<td>To evaluate the MCO's Disease Management program.</td>
<td>LOD #29: – Combined with 20</td>
</tr>
<tr>
<td>22</td>
<td>QM/QI Program Description and Associated Work Plan</td>
<td>Annually</td>
<td>To monitor and review the MCO's Annual QM/QI Program Description and Associated Work Plan to include goals, objectives, structure, and policies and procedures that address continuous quality improvement for physical and behavioral health.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>QM/QI Program Annual Evaluation</td>
<td>Annually</td>
<td>To monitor the MCO's QM/QI Program Evaluation for the previous year's activities.</td>
<td></td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
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<tr>
<td>24</td>
<td>Report on Performance Improvement Projects</td>
<td>Annually</td>
<td>To evaluate the MCO’s plans to implement Performance Improvement Projects (PIPs)</td>
<td>DISCONTINUED - LOD #29B.</td>
</tr>
<tr>
<td>25</td>
<td>CAHPS Results Report</td>
<td>Annually</td>
<td>To review and evaluate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report.</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Payment Reform</td>
<td>Quarterly &amp; Semi-Annually</td>
<td>To review MCO accomplishments, barriers, and challenges encountered within the network, engagement with providers, and evaluation of performance measures (ER visits, hospital readmission rates, asthma medication adherence, well child checks, diabetes, colorectal cancer screening, breast cancer screening, and total cost of care).</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Activities of the Member Advisory Boards</td>
<td>Semi-Annually</td>
<td>To review Member Advisory Board meeting agendas for general MCO membership, Native American representation, behavioral health, and community benefit subgroups.</td>
<td>LOD #29: Report 27 Combined with 27a and 32; now semi-annual.</td>
</tr>
<tr>
<td>27a</td>
<td>Subgroup of the Member Advisory Board (BH, Self-Directed, etc.)</td>
<td>10 days following each meeting</td>
<td>To monitor all privacy and security incidents that occur. The MCO will provide information pertaining to the date of the incident, date of notification to HSD’s privacy officer and the nature and scope of the incident. Additionally, information pertaining to the MCO’s response to the incident, mitigating issues taken by MCO to prevent similar incidents.</td>
<td>LOD #29: Combined with 27 and 32.</td>
</tr>
<tr>
<td>28</td>
<td>Privacy/Security Incident Report</td>
<td>Annually or more frequently as requested</td>
<td>To monitor and review the MCO’s Business Continuity and Disaster Recovery (BC-DR) Plan for review and written approval as specified by HSD.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>29</td>
<td>Business Continuity and Disaster Recovery Plan</td>
<td>Annually</td>
<td>To monitor and review the MCO’s Business Continuity and Disaster Recovery (BC-DR) Plan for review and written approval as specified by HSD.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>Report No.</td>
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<tr>
<td>30</td>
<td>Health Education Plan and Evaluation</td>
<td>Annually</td>
<td>To review the MCO's health education plan.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>31</td>
<td>Health Education Evaluation Report</td>
<td>Annually</td>
<td>To evaluate the MCO's Health Education Plan, relating to initiatives in the plan and present findings, lessons learned and performance improvement initiatives as a result of the findings.</td>
<td>LOD #29: Combined with 30.</td>
</tr>
<tr>
<td>32</td>
<td>Activities of the Native American Advisory Board Report</td>
<td>10 days following each meeting</td>
<td>To monitor the activities of the Native American Advisory Board, including a summary of the MCO's approach to inviting Native American advisory members, the meeting agenda, minutes, attendees and scheduling of the next meeting.</td>
<td>LOD #29: Combined with 27 and 27a.</td>
</tr>
<tr>
<td>33</td>
<td>Member Satisfaction Survey Report</td>
<td>Annually</td>
<td>To monitor and review the results of the member satisfaction survey (MHSIP).</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>34</td>
<td>Cultural Competency / Sensitivity Plan</td>
<td>Annually</td>
<td>To review the MCO's cultural competency/sensitivity plan.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>35</td>
<td>Electronic Visit Verification</td>
<td>Monthly</td>
<td>To review and evaluate the use of Electronic Visit Verification systems of the MCOs.</td>
<td>On Hold – LOD #29</td>
</tr>
<tr>
<td>36A</td>
<td>Critical Incidents Report - Monthly</td>
<td>Monthly</td>
<td>To monitor key metrics regarding critical incidents for members of Centennial Care and specific subpopulations.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>36</td>
<td>Critical Incidents Report - Quarterly</td>
<td>Quarterly</td>
<td>To monitor key metrics regarding critical incident reporting for specific subpopulations and the MCO’s actions in response to critical incidents.</td>
<td>LOD #29: Report Number changed from 36B to 36.</td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
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<tr>
<td>37</td>
<td>Grievances and Appeals Report</td>
<td>Monthly</td>
<td>To monitor member and provider grievances, appeals and fair hearings and to track MCO adherence to contractual timeframes.</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Provider Training and Outreach Plan and Evaluation</td>
<td>Annually</td>
<td>To monitor and review the MCO's plans for provider training and outreach.</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Provider Training and Outreach Plan Evaluation Report</td>
<td>Annually</td>
<td>To evaluate specific training topics such as (i) prior authorization process; (ii) Claims/Encounter Data submission; (iii) how to access ancillary providers; (iv) members rights and responsibilities; (v) quality improvement program/quality improvement initiatives; (vi) provider and Member Appeals and Grievances; (vii) recoupment of funds processes and procedures; (viii) Critical Incident management; and (ix) EPSDT benefit requirements, including preventative healthcare guidelines.</td>
<td>LOD #29B: Combined with #38</td>
</tr>
<tr>
<td>40</td>
<td>Over-and-Under Utilization of Services Report</td>
<td>Quarterly</td>
<td>To monitor the over- and under-utilization of prenatal services, behavioral health services, DME products/services, emergency room services, dental services, and pharmacy services for members.</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>Utilization Management Report</td>
<td>Quarterly</td>
<td>To monitor unduplicated member utilization of behavioral health services, physical health services, and long-term care services, and the amounts paid for these services.</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Prior Authorization Report</td>
<td>Quarterly</td>
<td>To capture information on services requiring prior authorization and examine changes and trends in authorizations and denials of services over time.</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>CMS-416</td>
<td>Annually</td>
<td>To monitor compliance with the Medicaid Children’s Health Insurance Program (CHIP) and federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.</td>
<td>DISCONTINUED - LOD #29</td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
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<tr>
<td>44</td>
<td>Pharmacy Report</td>
<td>Monthly</td>
<td>To monitor pharmacy utilization and cost, including dispensing fees, over- and under-utilization of drugs including controlled substances, utilization of formulary drugs, non-formulary drugs, over the counter, generic, and brand drugs.</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>Behavioral Health Members Services/CSA Report</td>
<td>Quarterly</td>
<td>To monitor the number and types of members served through CSAs and the types of services provided to such members.</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>Claims Payment Accuracy Report</td>
<td>Quarterly</td>
<td>To report the findings of the MCO’s internal audit of quarterly claim payments and to monitor the accuracy of those claims paid.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>47</td>
<td>Claims Activity Report</td>
<td>Quarterly</td>
<td>Claims Activity Section – To capture data related to the disposition of claims, timeliness of claims adjudication, payments on clean claims to providers, interest paid, and claim aging. This section of the report captures claims data separately for physical health providers, behavioral health providers, I/T/Us (Indian Health Service, Tribal health providers, and Urban Indian providers), and specialty-pay providers (day activity providers, assisted living providers, nursing facilities, home care agencies, and community benefit providers). Claims Payment Accuracy Section – To report the findings of the managed care organization’s (MCO’s) internal audit of quarterly claim payments and to monitor the accuracy of those claims paid.</td>
<td>LOD #29 C: Frequency of submission changed from Monthly to Quarterly</td>
</tr>
<tr>
<td>48</td>
<td>Patient Centered Medical Homes Report</td>
<td>Quarterly</td>
<td>To track (i) the number of Patient-Centered Medical Homes established, (ii) the number of members that were referred to and joined a PCMH, (iii) outcomes, including ER utilization and hospital admission and readmission,</td>
<td>LOD #29: Frequency of submission changed from Semi-Annually to Quarterly</td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
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<td>and (iv) PCMH NCQA recognition and other accreditation.</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Provider Network Development, Management Plan and Evaluation</td>
<td>Annually</td>
<td>To monitor and review the MCO's plans for developing and managing its provider network to ensure all medically necessary services are accessible and available.</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Provider Network Development and Management Evaluation Report</td>
<td>Annually</td>
<td>To evaluate the Provider Network Development and Management Plan that provides information on a summary of providers, monitoring activities, contract provider issues, network deficiencies and on-going activities for provider development and expansion.</td>
<td>LOD #29:– Combined with 49</td>
</tr>
<tr>
<td>51</td>
<td>Provider Suspensions and Terminations Report</td>
<td>Semi-Annually</td>
<td>To monitor the suspensions and terminations of providers and the number of members impacted.</td>
<td>LOD #29: Frequency of report submission changed from Quarterly to Semi-Annually</td>
</tr>
<tr>
<td>52</td>
<td>Care Plan Report</td>
<td>Monthly</td>
<td>To capture information on the number of members in an existing Home and Community-Based Services waiver program transitioning (with existing care plans) in the first year of the program (also known as the Transition Period).</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>53</td>
<td>PCP Report</td>
<td>Quarterly</td>
<td>To capture information regarding PCP member ratios, open panels and assignment/change activity for non-dual members.</td>
<td>LOD #29: Frequency of submission changed from Monthly to Quarterly</td>
</tr>
<tr>
<td>54</td>
<td>Telemedicine Report</td>
<td>Quarterly</td>
<td>To monitor the utilization of telemedicine services.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>55</td>
<td>Geographic Access Report</td>
<td>Quarterly</td>
<td>To monitor access to services by county and across urban, rural, and frontier counties.</td>
<td></td>
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<tr>
<td>Report No.</td>
<td>Report Title</td>
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<td>Report Objective</td>
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<tr>
<td>56</td>
<td>Program Integrity Report</td>
<td>Quarterly</td>
<td>To monitor fraud, waste, and abuse cases, preliminary investigations, suspicious activities, adverse actions, and financial program integrity activities of the managed care organization.</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Claims Activity Report - Weekly</td>
<td>Weekly</td>
<td>To capture information on the processing of claims and the timeliness of payments to providers on claims.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>58</td>
<td>Member Enrollment Materials Report</td>
<td>Quarterly</td>
<td>To monitor the timeliness of mailing member enrollment materials.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>59</td>
<td>Hiring Report</td>
<td>Quarterly</td>
<td>To monitor staffing levels of the managed care organization including vacancies and number of days positions are vacant.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>60</td>
<td>Systems Availability and Performance</td>
<td>Quarterly</td>
<td>To capture and monitor any MCO system availability and performance, including scheduled downtime.</td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>61</td>
<td>Medicaid School-Based Health Centers (SBHC)</td>
<td>Quarterly</td>
<td>To track the quantity and types of services billed by school-based health centers.</td>
<td>On Hold – LOD #29 (pending revision)</td>
</tr>
<tr>
<td>62</td>
<td>Value Added Services Report</td>
<td>Semi-Annually</td>
<td>To monitor the types and quantities of value added services offered by the MCO</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>63</td>
<td>Developmental Disabilities Specialty Dental Report</td>
<td>Quarterly</td>
<td>To monitor dental visits for members with developmental disabilities.</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Jackson Class Members Report</td>
<td>Quarterly</td>
<td>To monitor MCO performance in processing requests for and delivering new adaptive equipment and modifications or repairs to adaptive equipment.</td>
<td></td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
<td>Comment</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td>65</td>
<td>Member Rewards Report</td>
<td>Quarterly</td>
<td>The details of this report are still pending.</td>
<td>DISCONTINUED – LOD #29C</td>
</tr>
<tr>
<td>66</td>
<td>Health Homes Report</td>
<td>Quarterly</td>
<td>To track (i) the number of Health Homes established; (ii) the number of members referred to and joined a Health Home; (iii) outcomes, including ER utilization and hospital admissions and readmissions.</td>
<td>On Hold – LOD #29 This report is in development</td>
</tr>
</tbody>
</table>
18. B: Systems Availability Incident or Event Report

<table>
<thead>
<tr>
<th>MCO Name</th>
<th>Report Date</th>
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</table>

<table>
<thead>
<tr>
<th>Name of System Affected</th>
<th>Critical or Non Critical</th>
<th>Functionality of Affected System</th>
<th>Description of Event</th>
<th>Extent of Data Impact/Data Loss</th>
<th>Event Start Date and Time</th>
<th>Event End Date and Time</th>
<th>Event Duration</th>
<th>Recovery Action(s)</th>
<th>Corrective Action Plan, If Applicable</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
18 QUALITY

Revision dates:

Effective date: March 1, 2016

PERFORMANCE IMPROVEMENT PROJECT (PIP)

In addition, to the two PIPs outlined in the HSD MCO Contract (one on long term services and one on services to children), the MCO shall be required to do the two following PIPs based on the most current CMS Adult Core Set. The goal of the below PIPs are to continue the goals of the expiring CMS Adult Medicaid Quality Grant.

1. Diabetes prevention and enhanced disease management:
   A. PQI01-AD: Diabetes, Short-Term Complications Admission Rate (NQF #0272)
   B. HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF #0057)

2. Screening and Management for clinical depression
   A. AMM-AD: Antidepressant Medication Management (NQF #0105)
   B. CDF-AD: Screening for Clinical Depression and Follow-Up Plan (NQF #0418)

These PIPs shall follow all CMS guidelines and will be reviewed annually by the EQRO based on the most current EQRO contract, Performance Measure (PM)/PIP work plan.