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

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GENERAL REQUIREMENT

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

The MCO is required to submit a Notification, Narrative and Transition Plans A and B to its Contract Manager on anticipated changes to the network. The Manager for either the 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.

NOTIFICATION

The Notification must include the following:
1. Date.
2. Name of provider or facility.
3. Type of Service Region.
4. Location (address)/city of the provider or facility closing.
5. Total number of members affected and number of Consumers <=21 and >21.
6. Nature of the change.
7. Anticipated Date of Closure.
8. Transition plans required.
9. Narrative due date.
10. If the MCO determines that transition plans will be required, the Notification will also include the following information.
12. Name of MCO staff responsible for the Transition and deliverables.

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

**TRANSITION PLAN A – OVERALL TRANSITION TEMPLATE**
1. Preplanning.
3. Transition Planning.
4. Communication with the state.
5. Care Coordination.
6. Other requirements as needed depending on circumstances of closure.

**TRANSITION PLAN B – CLIENT SPECIFIC TEMPLATE**
1. Client Name.
2. Medicaid Number.
3. Date of Birth.
4. Parent or Legal Guardian (if applicable).
5. Services currently receiving.
7. Date of Discharge (if applicable).
8. New Provider (or anticipated new provider).
9. Date or anticipated date of transition.
10. First appointment date (for outpatient services).
11. Care Coordination and CSA (if applicable).
12. Special Conditions/Arrangements/Comments (e.g. barriers to transition).
13. CYFD – JJS or PS staff involvement (if applicable).
CORE SERVICES AGENCIES (CSA)
The MCOs, in designating additional or new Cores Services Agencies (CSAs) shall work together to:

1. Develop a Request for Application (RFA) in conjunction with the HSD (MAD and BHSD on behalf of the Collaborative). The RFA must include all services to be provided by the CSA, all eligibility requirements, all expectations regarding reporting, intake, discharge, outcomes and required activities to be performed by the CSA as well as any other contractual requirements determined jointly between the MCOs and the state staff.

2. Develop one system for processing the applications that ensures that all proposals are received and tracked. Agencies must receive a receipt confirmation and the MCOs will maintain a complete inventory of all proposals received.

3. Screen all applications according to defined pre-screening qualifications as required in the RFA in accordance with the time line in the RFA.

4. Prepare summary documents detailing the applicants who met the pre-qualifications and those who did not for review by the HSD.

5. Hold the mandatory bidder’s conference as described in the RFA and time line.

6. Develop a process for receiving questions from applicants and write a draft set of responses to be submitted to HSD staff in accordance with the time line established in the RFA.

7. Revise and post the final answers in accordance with the time line in the RFA.

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

1. Identify a review team that will include state staff.

2. Provide training to the review team regarding the RFA process and scoring document.

3. Distribute the provider RFA applications to the review team along with score sheets and any written guidance and the questions and responses.

4. Coordinate the logistics of the review process.

5. Maintain written documentation of the review team recommendations. This will include narratives for each section and an over-all score for each applicant.

6. Draft a summary of the recommendations for HSD staff.

7. Participate in the presentation of recommendations at a designated Collaborative meeting.

8. Send notification letters to all applicants and maintain a tracking system of the notifications.

9. Identify in writing performance issues of individual awardees for insertion into the CSA contract.

10. Notify the designated HSD staff of any formal complaints or protests from unsuccessful applicants.

IMPLEMENTATION AND OVERSIGHT OF CSA’s

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

2. The MCOs will meet regularly with the HSD staff to:
   a. Participate in the development of topics for implementation and training and coordinate all logistics for trainings and meetings with HSD staff.
   b. Identify and address problems and ongoing needs and concerns of the CSAs.
3 MEMBER EDUCATION

Revision Dates: August 15, 2014
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.

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

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

MEMBER EDUCATION PRIOR APPROVAL PROCESS
The MCO shall submit to HSD, through its Contract Manager, all written materials that will be distributed to Members (referred to as Member Materials). This includes but is not limited to Member Handbooks, Provider Directories, Member Newsletters, Member ID cards and, upon request, any other additional, but not required, materials and information provided to Members designed to promote health and/or educate Members.

All Member Materials must be submitted to HSD in electronic file media, in the format prescribed by HSD. The 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) Calendar Days from the date of submission.

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.
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.

**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 copies will be retained by the consumer run business and HSD. The MCOs will be responsible for the cost of the training and documentation. In subsequent
years, if the training material changes, the MCOs would be responsible for modifying the existing manual and providing the new version to the consumer run business and HSD.

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

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.

The MCO, through its care coordination monitoring, will ensure, at a minimum:

1. 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.

2. 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 comprehensive needs assessment and reassessment process;
   e. care plans are appropriate and adequate to address the Member’s needs;
   f. services are delivered as described in the care plan and authorized by the MCO;
   g. services are appropriate to address the Member’s needs (as defined in the policies and procedures);
   h. services are delivered in a timely manner;
   i. service utilization is appropriate;
   j. service gaps are identified and addressed in a timely manner (as defined in the policies and procedures);
   k. minimum care coordinator contacts are conducted;
   l. care coordinator-to-Member ratios are appropriate; and
   m. 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.

3. The MCO will use an electronic case management system that includes the functionality to ensure compliance with all requirements specified in the 1115(a) Waiver, federal and State statutes, regulations, the contract and the MCO’s policies and procedures. The functionality will include but not limited to the ability to:
   a. Capture and track key dates and timeframes, including, but not limited to, as applicable, enrollment, date of development of the care plan, date of authorization of the care plan, date of initial service delivery for each service in the care plan, date of each level of care and needs reassessment, date of each update to the care
plan, and dates regarding transition from an institutional facility to the community;
b. Capture 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, including notes regarding how such 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 purpose of an initial Health Risk Assessment (HRA) is to identify the Member’s abilities, needs, preferences and supports and to determine the care coordination level. The MCO will conduct an HRA per HSD guidelines and processes, together with the MCO’s policies and procedures, for the purpose of (i) introducing the MCO to the Member, (ii) obtaining basic health and demographic information about the Member, (iii) assisting the MCO in determining the level of care coordination needed by the Member, and (iv) determining the need for a detailed comprehensive needs assessment. During Steady State, the HRA shall be completed within (30) calendar days of the Member’s enrollment with the MCO.

Members in care coordination Level 1 receive an annual HRA; after an initial HRA, those in Levels 2 and 3 will not have an annual HRA since they will have a comprehensive needs assessment. Those members residing in a nursing facility do not require an HRA; when the resident is ready to transition back into the community, the MDS and CNA will be used to determine the care coordination level.

The MCO will make reasonable efforts to contact Members to conduct an HRA. Reasonable efforts means documentation of at least three (3) separate attempts to contact the Member which includes at least one (1) attempt to contact the Member at the number most recently reported by the Member (if a phone number is available), and (1) attempt to contact the Member using the
Member’s last reported residential address. The (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 an HRA. Documentation of the three (3) attempts must be included in the Member file. All attempts shall occur on three (3) different Calendar Days, at different hours of the day, including evening and after business hours.

**COMPREHENSIVE NEEDS ASSESSMENT**

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

During Steady State, the MCO shall:

1. Accept the Member’s nursing facility level of care determination, previously completed by HSD or its designee, until redetermination of the Member’s Medicaid eligibility or scheduled level of care assessment, whichever date is earlier.
2. Continue providing services previously authorized by HSD or its designee in the Member’s approved Home and Community-Based care plan or Behavioral Health Treatment or service plan, without regard to whether such services are being provided by Contract or Non-Contract providers and shall not reduce these services until the MCO conducts a comprehensive needs assessment and develops a care plan in accordance with the Contract, Section 4.4.9.
3. Schedule a comprehensive needs assessment within fourteen (14) Calendar Days of the Member receiving a care coordination level 2 or 3 assignment via the HRA; and Complete the comprehensive needs assessment within thirty (30) calendar days of the Health Risk Assessment (HRA), reminding members at least two weeks prior to the date scheduled for the assessment, through the most effective means of communication, about their scheduled date.
4. Should the MCO become aware of any significant change in a Member’s medical condition, signifying increased needs, prior to the scheduled time for the comprehensive needs assessment, conducting the assessment must be expedited and an update of the Member’s care plan executed, initiating any needed changes in services within ten (10) calendar days of becoming aware of the change in the Member’s condition and needs.

Comprehensive needs assessments must be performed by the MCO, through the utilization of an assessment tool that has been previously approved by HSD, assessing the Member’s medical/physical health, behavioral health, long term care and social needs. The assessment tool may include the identification of targeted needs related to improving health, functional outcomes, or quality of life outcomes (e.g., related to targeted health education, pharmacy management, or increasing and/or maintaining functional abilities, including provision of covered services). Any changes to the assessment tool must be approved by HSD thirty (30) calendar days prior to use by the MCO. The comprehensive needs assessment must be conducted by a staff professional care coordinator, employed by the MCO. While additional partnership with community health workers, community health representatives, community
behavioral health representatives and other advocates; is encouraged, the comprehensive needs assessment is the sole responsibility of the MCO care coordinator.

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

CNAs are performed face-to-face with the Member and collateral parties in the home, unless an exception has been granted by HSD. Home setting is defined as the primary residence for the Member in the community, which can include personal single home dwelling, family member’s residence where Member may be living, assisted living facility, temporary shelter, and so forth, where there is an identifiable address. If the Member is homeless, the comprehensive needs assessment may be conducted at a location, mutually agreeable to the Member, such as a church meal site program, community non-profit organization center, community mental health agency, food bank site, etc. Exceptions to requirement for assessments being completed in the home must be made directly to the MCO contract manager at HSD and will be reviewed on an individual case by case basis. Alternate locations submitted by the MCO to HSD for review, should be assessed for privacy to ensure that the Member’s Protected Health Information (PHI) is not jeopardized.

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

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

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 screen (CAGE) and history; family medical and behavioral health, (mental health and substance use/abuse), history; cognitive capacities, (including evaluation of alertness, orientation, history of head/brain injury); health-related lifestyle (smoking, food intake/nutrition, sleep patterns, exercise, continence); and functional abilities, including Activities of Daily Living/ADLs (mobility, grooming, bathing, eating, medications concerns (i.e. self-administration and safety) and Instrumental Activities of Daily Living/IADLs (i.e. money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, grocery shopping).

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

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

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); IADLs; Individualized Education Plan (IEP); and Individual Service Plan (ISP) for Developmental Disabilities or Medically Fragile 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.
REASSESSMENTS
The CNA shall be conducted at least annually for Level 2 Care Coordination and semi-annually for Level 3 Care Coordination, to determine if the care plan is appropriate for the Member and if a higher or lower level of care coordination may be needed. Additional comprehensive needs assessments may also be conducted, as the care coordinator deems necessary, due to requests from the Member, provider, family member or legal representative or as a result of a change in health status and/or social support situation.

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

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

¹ The MCO will implement policies and procedures that will define and specify the qualifications, experience and training of each member of the care coordination team and ensure that functions specific to the assigned care coordinator are performed by a qualified care coordinator.


Managed Care Policy Manual  as of March 3, 2015
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:

- Level 1 care coordination: 1:1750;
- Level 2 care coordination: 1:75;
- Level 2 members residing in Nursing Facility: 1:125;
- Level 2 Self Directed Community Benefit 21 years of age and older: 1:100;
- Level 3 care coordination: 1:50;
- Level 3 members residing in Nursing Facility: 1:125;
- Level 3 Self Directed Community Benefit members 21 years of age and older: 1:75; and
- Care coordination for Members under 21 years of age who participate in the Self-Directed Community Benefit: 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 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 shall ensure that Members have a telephone number for direct contact with their care coordinator and/or a member of their care coordination team, (without being routed around through several contact points), during normal business hours (8 a.m. - 5 p.m. Mountain Standard Time). When the Member’s care coordinator or a member of the Member’s care coordination team is not available, the call shall be answered/facilitated by another qualified staff person in the MCO’s care coordination unit. Calls requiring immediate attention shall be “warm” transferred directly to another care coordinator, not letting call go to voice mail. After normal business hours, calls requiring immediate attention by care coordinator shall be handled by the Member services line, as stipulated by Section 4.15.1 of the contract.

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

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

1. Assigned care coordinator is no longer employed by the MCO;
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 shall develop policies and procedures regarding notice to Members of care coordinator changes initiated by either the MCO or Member, including notice of planned care coordinator changes initiated by the MCO.

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

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

**COMPREHENSIVE CARE PLAN 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. Members in
Level 1 care coordination will not need to have a care plan. The MCO is responsible for ensuring a care plan is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the care plan.

1. Comprehensive Care Plan Scope and Process. The MCO must establish a process to ensure coordination of care for members that includes:
   A. Coordination of the members health care needs through the development of the care plan;
   B. Collaboration with the member, member’s friends, family, members PCP, specialists, Behavioral Health providers, other providers, communities, and interdisciplinary team experts, as needed when developing the care plan, including documentation of all attempts to engage providers and other individuals identified in the development of the care plan;
   C. With the members consent to share information, the care plan should be shared and utilized by those involved in providing care to the member. (e.g. BH providers should be aware and take into consideration the members physical health care issues when working with the member); and
   D. Verification of all decisions made regarding the member’s needs and services, and ensures all information is documented in a written, comprehensive care plan.

2. Comprehensive Care Plan Development and Management
   A. The Care Plan serves as a working and guiding tool of reference for integrating the member’s treatment plan(s) into a language that the member and or/family member can understand. The MCO shall develop and authorize the CCP within fourteen (14) Business Day of completion of the comprehensive needs assessment.
   B. 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 members completed care plan to the member, members legal representative as applicable or other providers authorized to deliver care to the member in a format that is easily readable (e.g. 12 font).
      c. Confirm that family, providers, or any other relevant parties are included in the treatment and planning of the members care plan.
      d. Ensure timelines for the development and implementation and/or update the care plan as needed.
      e. Facilitate treatment and coordinate with providers to assist the member and his or her family with navigating the system scheduling appointments, arranging transportation, or advocating for the member as needed.
      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. Maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the members 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.

i. Identify changes to member’s risk, address those changes and update the member’s risk agreement as necessary.

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).

C. The Comprehensive Care Plan Required Elements include the following:

a. Pertinent member demographics and enrollment data.

b. Ensure implementation of interventions and the dates by which the interventions must occur and identify specific agencies or organizations with which treatment must be coordinated, including non-Medicaid providers.

c. Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.

d. Members’ current status, including present levels of function in physical, cognitive, social, and educational domains.

e. Member or family barriers to receiving treatment, such as a member or family member’s ability to travel to an appointment.

f. Identify the member or family’s strengths, resources, priorities and concerns related to achieving mutual recommendations made in caring for the member receiving services.

g. Services recommended achieving the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member’s desired outcomes.

h. Identified services provided by natural supports that are scheduled to be enhancers and back-up (including emergency purposes) to services that are authorized by the MCO.

i. An interdisciplinary team including but not limited to: the care coordinator, social worker, registered nurse, medical director, and PCP must be identified to develop, implement and update the care plan as needed.

D. Comprehensive Care Plan Revisions

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

   1. Risk of significant harm. In this case the care coordination team will convene within one calendar day, in person or by
teleconference; if necessary the care plan will be modified accordingly within 72 hours;
2. Major medical change;
3. The loss of a primary caregiver or other significant person;
4. A serious accident, illness, injury or hospitalization that disrupts the implementation of the care plan;
5. Serious or sudden change in behavior;
6. Change in living situation;
7. Proposed change in services or providers (e.g. Community Benefit);
8. It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect or exploitation;
9. Any team member requests a meeting to propose changes to the care plan;
10. Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or
11. Requested by HSD.

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

E. 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 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:

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

**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 medical staff of the MCO. The member may request one or two people to be in attendance. The intention of the meeting with the participant is to:

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.
8. 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.)
9. Schedule updates between participants, MCO staff on a regular basis.
10. Maintenance of documentation is with MCO, participant and natural supports.

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

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

Revision Dates: August 15, 2014

Effective Date: January 1, 2014

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

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

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

1. The comprehensive needs assessment.
2. PASRR.
3. 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.

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

MEMBERS WITH SPECIAL CIRCUMSTANCES

The following members may require additional or distinctive assistance during a period of transition. This includes members with:

1. Medical conditions or circumstances such as:
   a. Pregnancy (especially women who are high risk and in third trimester, or are within 30 calendar days of their anticipated delivery date).
   b. Major organ or tissue transplantation services which are in process.
   c. Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing facilities, or other facilities;
   d. Significant medical conditions (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing specialist care and appointments; and/or
   e. Significant behavioral health conditions (e.g., SMI, SED, SUD and COD) that require ongoing specialist care and appointments.
2. Members who are in treatment such as:
   a. Chemotherapy and/or radiation therapy.
   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.
   e. Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.
4. Members who at the time of their transition have received prior authorization or approval for:
   a. Scheduled elective surgery or surgeries;
   b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits;
   c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the thirty-day period;
   d. Appointments with a specialist located out of the MCO service area, and
   e. Nursing facility admission.

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

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

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

**TRANSITIONS OF CARE FROM HIGHER LEVELS OF CARE TO A LOWER LEVEL OF CARE**

2 Please see the CMS Standard Terms and Conditions for New Mexico’s 1115 Waiver.
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.

**NOTIFICATIONS REQUIRED OF MCO’s**

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

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

MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, sub-contractors or other providers, as appropriate during times of transition.

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

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

**TRANSITIONS FROM A NURSING FACILITY TO THE COMMUNITY**

If a member is determined to no longer need long term care in a nursing facility, and the member is determined eligible for Community Benefits, the care coordinator shall facilitate the development of and complete a transition plan, which shall remain in place for a minimum of sixty (60) calendar days from the decision to pursue transition or until the transition has occurred and a new care plan is in place. The member's care coordinator must be involved in the transition process in order to assure that continuity and quality of care for the member is maintained. The care coordinator must administer the Comprehensive Needs Assessment (CNA) in the nursing facility to determine the community benefits and services upon the member’s discharge.
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:

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

MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE

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

1. Authorization of treatment by the receiving MCO on an individualized basis. The receiving MCO must address contracting for continued treatment with the institution on a negotiated fee basis, as appropriate.
2. Notification to the hospital and attending physician of the transition by the relinquishing MCO. The relinquishing MCO must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving MCO for authorization of continued services. If the relinquishing MCO fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing MCO will be responsible for coverage of services rendered to the hospitalized member for up to 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 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.

ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS

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

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

Receiving MCOs are also responsible for coordinating the transition of pregnant women to maintain continuity of care. Pregnant women who transition to a new MCO within the last
trimester of their expected date of delivery must be allowed the option of continuing to receive services from their established physician and anticipated delivery site.
6 NURSING FACILITY LEVEL OF CARE DETERMINATIONS

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

GENERAL INFORMATION
This policy establishes guidelines and restrictions for all MCOs regarding nursing facility services.
1. Definitions: See 8.312.2UR.
2. Nursing Facility (NF) Medical Eligibility Criteria: See 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. (See the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria for documentation requirements.) All requests for prior authorization are submitted to the resident’s MCO by fax.

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

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.
APPENDIX A: NURSING FACILITY LEVEL OF CARE COMMUNICATION FORM

Nursing Facility Level of Care

Communication Form

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

I. Requestor Information

<table>
<thead>
<tr>
<th>Date of Request</th>
<th>Click here to enter a date.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM</td>
<td>Choose an item. Name</td>
</tr>
<tr>
<td></td>
<td>Name Click here to enter text.</td>
</tr>
<tr>
<td>Company</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Fax</td>
<td>Click here to enter text.</td>
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<tr>
<td>Phone</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>TO</td>
<td>Choose an item. Name</td>
</tr>
<tr>
<td></td>
<td>Name Click here to enter text.</td>
</tr>
<tr>
<td>Company</td>
<td>Click here to enter text.</td>
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<tr>
<td>Fax</td>
<td>Click here to enter text.</td>
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<tr>
<td>Phone</td>
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</table>

II. Communication:

Nursing Facility Resident Information:

<table>
<thead>
<tr>
<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>
</tr>
</tbody>
</table>

a. ☐ Request For Information

- Missing Member Demographics
- Missing MDS Required fields: Click here to enter text.
- MDS not within the service time frame requested
- Need a valid physician order for: Click here to enter text.
- Need member’s Level I PASSR
- Need member’s Level II PASSR
- Need current H&P
- 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.

b. ☐ Member MCO Update

- Member current MCO selection: Click here to enter text.
- Member previous MCO assignment: Click here to enter text.
**APPENDIX B: NURSING FACILITY LEVEL OF CARE NOTIFICATION FORM**

### Nursing Facility Level of Care Notification Form

#### I. Nursing Facility Prior Authorization Request

<table>
<thead>
<tr>
<th>Nursing Facility Information</th>
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</thead>
<tbody>
<tr>
<td>Date of Request</td>
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</tr>
<tr>
<td>Nursing Facility Name</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>NF Contact Name</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Nursing Facility Fax</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Nursing Facility Phone</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Nursing Facility Resident Information:</th>
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</thead>
<tbody>
<tr>
<td>NF Resident Name</td>
<td>Click here to enter text.</td>
</tr>
<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>
</tr>
<tr>
<td>NF Admission Date</td>
<td>Click here to enter a date.</td>
</tr>
<tr>
<td>Selected MCO</td>
<td>Choose an item.</td>
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<tr>
<td>Resident Rep Name</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Rep Phone</td>
<td>Click here to enter text.</td>
</tr>
<tr>
<td>Resident Rep Address</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Requesting Service</th>
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</thead>
<tbody>
<tr>
<td>NFLOC Type</td>
<td>Choose an item.</td>
</tr>
<tr>
<td>Service Begin Date</td>
<td>Click here to enter a date.</td>
</tr>
<tr>
<td>Service End Date</td>
<td>Click here to enter a date.</td>
</tr>
</tbody>
</table>

**Documentation Requirements:**

**Initial Request:**
- ☐ MDS
- ☐ Physician Order
- ☐ PASRR Level I and PASRR Level II if indicated by PASRR Level I
- ☐ History & Physical

**Continuation Stay:**
- ☐ Most recent MDS
- ☐ Physician Order
- ☐ Physician Progress Notes
- ☐ History & Physical

#### II. Utilization Management (For MCO Use Only)

<table>
<thead>
<tr>
<th>Review Information</th>
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<tbody>
<tr>
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<td>Authorization Number</td>
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</tr>
<tr>
<td>NFLOC Begin Date</td>
<td>Click here to enter a date.</td>
</tr>
<tr>
<td>NFLOC End Date</td>
<td>Click here to enter a date.</td>
</tr>
<tr>
<td>Approved Bed Begin Date</td>
<td>Approved Bed End Date</td>
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</table>

<table>
<thead>
<tr>
<th>LNF Factors:</th>
<th>HNF Factors:</th>
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</thead>
<tbody>
<tr>
<td>☐ Dressing</td>
<td>☐ Oxygen</td>
</tr>
<tr>
<td>☐ Bathing</td>
<td>☐ Orientation / Behavior</td>
</tr>
<tr>
<td>☐ Eating</td>
<td>☐ Medication Administration</td>
</tr>
<tr>
<td>☐ Meal Preparation</td>
<td>☐ Rehabilitation Therapy</td>
</tr>
<tr>
<td></td>
<td>☐ Skilled Nursing</td>
</tr>
<tr>
<td></td>
<td>☐ Feeding</td>
</tr>
<tr>
<td></td>
<td>☐ Mobility / Transfer</td>
</tr>
<tr>
<td>☐ Transfer</td>
<td>☐ Mobility</td>
</tr>
<tr>
<td>☐ Mobility</td>
<td>☐ Toileting</td>
</tr>
<tr>
<td>☐ Toileting</td>
<td>☐ Bowel/Bladder</td>
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<tr>
<td>☐ Bowel/Bladder</td>
<td>☐ Daily Medication</td>
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</table>

<table>
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<th>Approved NFLOC Type:</th>
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<tbody>
<tr>
<td>Choose an item.</td>
<td></td>
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</table>

**Comments:** Click here to enter text.
7 COMMUNITY BENEFIT

Revision Dates: August 15, 2014

Effective Date January 1, 2014

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

Registration For The Community Benefit For Members Not Otherwise Medicaid Eligible

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

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

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

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

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

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

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

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

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Any individual has the right to register/apply for multiple waivers at the same time. An individual must be a resident of the State of New Mexico in order to be registered. Residency is determined using the State’s Medicaid eligibility.

For purposes of establishing eligibility for the Community Benefit services, a waiver or waivers are those approved by the Centers for Medicare & Medicaid Services (“CMS”) for the State of New Mexico for Medicaid benefits. Individuals may apply by calling or appearing in person to the ADRC. Individuals should note that the Central Registry records such information as: (1) the demographic information about the applicant; (2) the date of registration, and (3) the applicant’s specific needs.

Individuals are also required to complete a pre-assessment which aids the ADRC staff in directing the applicant to the appropriate category of registration: Regular, Expedited, or Community Reintegration, which are defined as: Community Reintegration (“CRI”) – a registrant who is in a licensed skilled nursing facility (“SNF”) at the time of registration. In order to be eligible for CRI, the registrant must have resided in a SNF for 90 consecutive days, which may include time the registrant was in a hospital and returned to the SNF without a break in service. CRI provides individuals the opportunity to move out of a SNF and back into the community.

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

Individuals diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC) may be registered with an expedited category of registration. Once registered, the ADRC will notify HSD/MAD Agency Based Community Benefit program manager and an expedited allocation will be released. The MCO will conduct the Comprehensive Needs Assessment (CNA) and Nursing Facility Level of Care (NFLOC) to verify the AIDS or ARC diagnosis and assist with access to Community Benefits.

Individuals that no longer qualify for the Medically Fragile Waiver and are ventilator dependant may also be registered with an expedited category of registration. University of New Mexico, Center for Development and Disability Medically Fragile Case Management Program will notify HSD/MAD Agency Based Community Benefit program manager of the request to transition and an expedited allocation will be released.

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

**THE ALLOCATION PROCESS**
The ADRC manages the Central Registry.
The HSD/MAD manages the allocation process. The HSD/MAD Director determines allocation frequency based on available funding.

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.
2. Change a registrant’s category of registration if the ADRC obtains information that justifies the change, e.g., a registrant leaves a SNF before the 90-day requirement is met.
3. Close/Deactivate a registration in accordance with the closing of an allocation as described herein.

HSD/MAD shall maintain a list of registrants with the category of registration, sorted by the date of registration.

When the HSD/MAD Director determines that an allocation should be made, the allocation process begins with the Letter of Interest (“LOI”) packet being sent to the registrant. The registrant is notified that there is an allocation available and is asked to respond by returning a completed Primary Freedom of Choice Form (“PFOC”). The LOI packet shall contain:

1. LOI.
2. PFOC, attachment A.
3. Refusal of Services, attachment B.
4. Return envelope addressed to HSD/MAD, stamped with “Allocation Packet”.

Time frames for the LOI packet:

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

Processing PFOCs. Once HSD/MAD receives the PFOC, HSD/MAD will sort and review the PFOCs to ensure that the form is complete and signed by the registrant.

1. If the PFOC is not complete or accurate, the PFOC will be returned to the registrant, identifying the correct information required to process the PFOC, and providing the registrant up to thirty (30) calendar days to return the PFOC. Failure to timely return the PFOC within the 30-day time period will result in closure as described herein.
2. If the PFOC is complete, HSD/MAD will process it and send a Notice of Allocation (“NOA”) letter to the registrant, with a copy of the PFOC and an HSD/MAD 100-Medicaid application for assistance. In addition, a copy of the NOA, PFOC and cover sheet is faxed to the registrant’s local HSD/ISD office and to the registrant’s MCO.
**ELIGIBILITY**
Registants must meet two (2) types of eligibility initially and annually to receive and continue receiving Community Benefits:

1. **Medical Eligibility.** The medical eligibility packet is completed by the registrant’s MCO. In order to be medically eligible, the registrants must meet nursing facility level of care (NF LOC), which is, at a minimum, daily hands-on assistance with two or more ADLs.

2. **Financial Eligibility.** In order to be financially eligible, income must be under the Institutional Medicaid (ICM)/Waiver maximum determined by HSD/ISD.

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

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

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

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

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

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

1. New registration.
2. Change in category of registration.
3. When the State is unable to contact the registrant by telephone.
4. When an allocation becomes potentially available for the registrant.
5. When an allocation is complete.
6. When a registration is closed/inactivated for any reason other than a completed allocation, with the exception of when the State has been notified that the registration has expired. In such a situation, no letter will be sent to the registrant.

**UNDELIVERABLE NOTICE**

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


Effective Date January 1, 2014

GENERAL INFORMATION

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

DEFINITIONS

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. APS: Adult Protective Services Division of the Aging and Long-Term Services Department.
5. Care Coordinator or 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. 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. HSD: New Mexico Human Services Department.
14. 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. **ISD**: Income Support Division, New Mexico Human Service Department.

18. **Level of Care or 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 SERVICE STANDARDS

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

The standards address each service covered by the ABCB. Individuals served through this program will expect to receive services that meet these standards.

These standards define the services offered as approved by the Centers of Medicare & Medicaid (CMS). The ABCB services are a supplement to the member’s natural supports and are not intended to replace family support. The ABCB is not a twenty-four (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 Care Plan as developed with the member and the MCO Care Coordinator (CC).

ABCB COVERED SERVICES

Adult Day Health Services

Adult Day Health Services provide structured therapeutic, social and rehabilitative services designed to meet the specific needs and interests of ABCB service members as determined by the Plan of Care incorporated into the Care Plan. The services are generally provided for two (2) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, by a licensed adult daycare, community based facility that offers health and social services to assist participants to achieve optimal functioning. Private Duty Nursing services and Skilled Maintenance Therapies (physical, occupational and speech) may be provided in conjunction with Adult Day Health services, 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-administrated 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.
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 life style.
- Protecting each member’s right to privacy.
- Nurturing the spirit of each member.
- Involving family and friends in care planning and implementation.
- Providing a safe residential environment.
- Providing safe community outings or activities.

1. SCOPE OF SERVICES

A. Core services provide assistance to the member in meeting a broad range of activities of daily living. Specific services may include the following:
   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.
C. Provider agencies must comply with the provisions of Title II and III of the American’s with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).

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

E. Providers of Assisted Living are required to maintain staffing ratios and patterns that will meet the individual members’ needs as identified in the Care Plans and the agency’s Plan of Care.

F. The Assisted Living program will develop a Plan of Care for each member based on the assessment of the needs of the member, and include strategies to meet those needs. The Plans of Care must be evaluated for effectiveness, and revised as the needs of the members change. The Plan of Care is separate and incorporated into the Care Plan.

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

H. Definition of “Home-Like” Environment: A “home-like” environment must possess the following structural features prior to the placement of the ABCB services recipient. Meeting these requirements is the financial responsibility of the Assisted Living Provider:
   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 be provided with an opportunity to make decisions about their day to day activities including visitors, 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 appropriate staff having keys to doors; Members share units only at the member’s choice; Members have freedom to furnish and decorate sleeping or living units; The setting is physically accessible to the member.

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 participant with a developmental disability and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the participant include: assessments, evaluations, treatments, interventions, follow-up services and assistance with challenging behaviors and coping skill development. Services for the parents, family members and DSPs include training in dealing with challenging behaviors and assistance with coping skill development at home and in the community.

1. SCOPE OF SERVICES
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:

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

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

Community Re-integration Registration for the ABCB can be completed by calling the Aging and Disability Resource Center (ADRC). Once a 90 continuous day stay is confirmed by the HSD/MAD and funding is available, a community re-integration allocation is granted. The HSD/MAD sends the allocation packet to the registrant/representative. The allocation paperwork (Primary Freedom of Choice form PFOC) must be returned to the HSD/MAD within 45 calendar days or the allocation will be closed and the registrant would need to re-register and wait for another allocation. If an extension is needed, HSD/MAD must be notified to grant the extension.
Once the PFOC is received by the HSD/MAD, it is faxed to the local Income Support (ISD) office. It is also faxed to the MCO. Once the allocation has been granted, the registrant may leave the nursing home if a safe and appropriate discharge is arranged.

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

Once medical and financial eligibility is approved, ABCB services will be initiated.
COMMUNITY TRANSITION SERVICES
Community Transition Services are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a skilled nursing facility to a living arrangement in the community where the person is directly responsible for his or her own on-going living expenses.

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.

4. LIMITS OR EXCLUSIONS
   A. Eligible members must have a landline phone.
EMPLOYMENT SUPPORTS

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

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

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

Employment Supports will be provided by staff at current or potential work sites. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations; supervision and training required by eligible members receiving services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

1. SCOPE OF SERVICES

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

A. Basic Components

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

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 (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursements for Employment Support services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS
Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: 1) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2) Payments that are passed through to users of supported employment programs; or 3) Payments for training that is not directly related to an individual's supported employment program. Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.
ENVIRONMENTAL MODIFICATIONS
Environmental Modification services include the purchase and/or installation of equipment and or making physical adaptations to an eligible member’s residence that are necessary to ensure the health, welfare, and safety of the member or enhance the member’s level of independence.

1. SCOPE OF 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.

A. Duplicate Adaptations: No duplicate adaptations, modifications or improvements shall be approved regardless of the payment source. For example, if the client has a safe and usable ramp, a replacement ramp shall not be approved.

B. New Construction: This service cannot be used to fund apartment buildings and Assisted Living facilities.

2. AGENCY PROVIDER REQUIREMENTS
A. The environmental modification provider must comply with all New Mexico state laws, rules and regulations, including applicable building codes.

B. The environmental modification provider must have valid New Mexico regulation and licensing department, construction industries division GB02 class construction license pursuant to the Construction Industries Licensing Act NMSA 1978, Section 60-13-3.

C. The environmental modification provider must provide a (1) one-year warranty from the completion date on all parts and labor.

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

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

F. The environmental modification provider must provide or secure licensed MCO(s) or approved vendor(s) to provide construction/remodeling services, provide administrative and technical oversight of construction projects;
G. The environmental modification provider must provide consultation to family members, waiver providers and MCOs concerning environmental modification projects to the individual’s residence, and inspect the final environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation.

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

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

3. REIMBURSEMENT
   Environmental Modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on a project basis, One (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.

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4. LIMITS OR EXCLUSIONS
   A. Environmental modification services are limited to five thousand dollars ($5,000.00) every five (5) years.
   B. Administrative Costs of the provider of the environmental modification services will not exceed fifteen percent (15%) of the total cost of the environmental modification project for each project managed by the MCO.
HOME HEALTH AID
Home Health Aide Services provide total care or assist an eligible member in all activities of daily living. Total care is defined as: the provision of bathing (bed, sponge, tub, or shower), shampoo (sink, tub, or bed), care of nails and skin, oral hygiene, toileting and elimination, safe transfer techniques and ambulation, normal range of motion and positioning, adequate oral nutrition and fluid intake.

1. SCOPE OF SERVICES
The Home Health Aide services assist the eligible member in a manner that promotes an improved quality of life and a safe environment for the eligible member. Home Health Aide services can be provided outside the eligible member's home. State Plan Home Health Aide services are intermittent and provided primarily on a short-term basis; whereas, Home Health Aide services are provided hourly, for eligible members who need this service on a more long term basis. Home Health Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. Home Health Aides perform an extension of therapy services, bowel and bladder care, ostomy site care, personal care, ambulation and exercise, household services essential to health care at home, assisting with medications that are normally self-administered, reporting changes in patient conditions and needs, and completing appropriate records.

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

2. AGENCY PROVIDER REQUIREMENTS
   A. The Home Health Aide (HHA) Agency must be an approved provider with HSD/MAD.
   B. HHA Qualifications:
      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 (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for home health aide services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
PERSONAL CARE SERVICES (PCS)

1. SCOPE OF 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.

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

5. CONSUMER’S RESPONSIBILITIES
   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. Verifying that services have been rendered and signing accurate time sheets/logs for submission to the PCS agency for payroll;
2. Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
3. Allowing the PCS provider to complete monthly home supervisory visits;
4. Participating in the CNA process, at least annually, in the consumer’s primary place of residence;
5. Participating in the development and review of the IPoC;
6. 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
7. 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;
   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 Paragraph (3) and Paragraph (5) (b and (d) above; if certified, a copy of a current and valid home health license must be
submitted annually along with proof of liability and workers’ compensation insurance;

i. Upon request, for approval to provide the consumer-delegated model of service, a copy of the agency’s written competency test for attendants approved by Medicaid or its designee; an agency may select to purchase a competency test or it may develop its own test; the test must address at least the following:

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); 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;
   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. Maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the Provider Participation Agreement (PPA);
   d. 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;
   e. 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;
   f. Providing either the consumer-directed or the consumer-delegated models, or both models;
   g. 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;
   h. Ensuring that each consumer receiving PCS services has a current approved IPoC on file;
   i. 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.

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

k. 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.

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

m. 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;

n. 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;

o. 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);

p. Informing the consumer and his/her attendant of the responsibilities of the agency;
q. Develop an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;
r. Provide an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;
s. 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
t. 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;

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

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

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;

1. 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 refer 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. The completed CNA or 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
deprecated);
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 finalized IPOC must contain a seven-day schedule, unless natural supports are identified or any other supporting documentation which indicates the member is self-sufficient for any other days of the week which are not included in the seven-day schedule. Only those services identified as IADLs, household support services, or certain ADL PCS such as meal preparation may be moved to another day, using the IPOC. The PCS agency must document more, and less, service time on the IPOC for specific day(s) during the week so long as the consumer has his/her daily needs met and the total weekly hours do not exceed the weekly task total. Consumers receiving services only a certain number of days of the week may not be allocated time for ADLs on days in which an attendant does not provide services (i.e., time will not be allocated for ADLs for seven calendar days if a consumer receives services only four calendar days during the week). Any tasks not performed by the attendant cannot be “banked” or otherwise saved for a later date.

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 consumer’s 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 proposed IPoC to the MCO for final review and approval;

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

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

7. 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

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

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

1. The consumer is requesting more hours/services;

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

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

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

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

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

7. The attendant does not want to complete the mandated trainings under the consumer-delegated model;
8. The consumer does not wish to comply with the Medicaid or PCS regulations and procedures; and
9. There is reason to believe that solicitation has occurred as defined in this policy in the, Solicitation/Advertising section in this policy.

b. The MCO will notify the consumer and both the originating agency and the receiving agency of its decision within 15 working-days after receiving the request. The consumer may verify that his/her request was received by the MCO.

c. A consumer who does not agree with the MCO’s decision shall utilize the MCO grievance and appeal process. Upon receiving notification of the resolution of the appeal or grievance by the MCO, a consumer may request a fair hearing pursuant to 8.352.2 NMAC, Recipient Hearings. The originating agency is responsible for the continuance of PCS while the hearing is pending, if requested timely by the consumer and approved by the MCO, as identified in the assessments for services section of this policy.

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

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 or may be discharged by HSD from receiving any PCS.
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 other 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; Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
   f. Misrepresenting itself as having affiliation with another entity; and
   g. 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
   F. Obtaining pertinent medical history.
   G. Observing and assessing the member’s condition.
   H. Administration of medications to include: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes.
   I. Providing wound care, suture removal and dressing changes.
   J. Monitoring feeding tubes (i.e. gastrostomy, naso-gastric, or jejunostomy including patency), including signs of possible infection
   K. Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal.
   L. Monitoring aspiration precautions.
   M. Monitoring administration of oxygen, ventilator management, and member’s response.
   N. Monitoring infection control methods.
   O. Monitoring seizure protocols.
   P. Collecting specimens (blood, urine, stool, or sputum) and obtaining cultures as ordered by the member’s primary physician.
   Q. Alerting the member’s physician to any change in health status.
   R. Monitoring nutritional status of the member and reporting any changes to the physician and nutritionist if available.
   S. Maintaining member intake and output flow sheets as ordered by the physician.
   T. Performing physical assessments including monitoring of vital signs and the member’s medical condition as warranted.
U. 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.

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

W. 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.

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

Y. Develop interventions to assist the member to achieve and promote health to meet the individual member’s needs.

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

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

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

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

H. The ABCB does not provide 24 continuous hours of nursing services for any member except as a Private Duty Nursing Respite service provider. This does not preclude the use of other funding sources for nursing such as Medicare or private pay etc., to supplement ABCB Service nursing services for a member.
NURSING RESPITE SERVICES

Nursing Respite services provide the member’s primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or caregiver’s illness as determined in the Care Plan. A primary caregiver is the individual who has been identified in the Care Plan and who assists the member on a frequent basis, i.e. daily or at a minimum weekly. It is not necessary for the primary caregiver to reside with the member in order to receive respite services. Nursing Respite services may be provided in the member’s home, in the respite provider’s home and in the community. Nursing Respite services may be provided by a Registered Nurse (RN), or a Licensed Practical Nurse (LPN). Respite services are limited to a maximum of 100 hours per Care Plan year. Nursing Respite services must not be provided by a member of the member’s household or by any relative approved as the employed caregiver. Specific services may include the following:

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

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

3. AGENCY PROVIDER REQUIREMENTS
   A. The provider agency of Nursing Respite Services must meet all requirements, certifications and training standards set forth by the HSD/MAD to provide Private Duty Nursing services, as described in the Private Duty Nursing service standards.
   B. Refer to the appropriate program standards for Private Duty Nursing services for additional information on certification requirements, supervision requirements, services, and program standards for the provision of Private Duty Nursing Respite Services.
   C. Supervision of Nursing Respite Service employees must be documented by the Nursing respite supervisor. The supervisor must be a staff member of the nursing respite provider agency and provide in-service training to the personnel providing the care.
   D. Supervision of Nursing Respite Services will be done at least quarterly. A Registered Nurse must supervise Private Duty Nursing Respite employees. The supervisory nurse must be on the staff or a MCO of the provider agency to supervise and provide in-service training to the personnel providing the care.
E. Nursing Respite service providers must maintain a current roster that is updated quarterly of Nurse Respite providers to provide services as requested by the member or family.
F. Nursing Respite service providers must immediately notify the MCO Care Coordinator if there is a change in the member’s condition, if the member refuses care or if the agency is unable to comply with the care delivery as agreed upon in the Care Plan.

4. AUTHORIZATION OF NURSING RESPITE CARE SERVICES
   A. Scheduling of hours for use of Nursing Respite Services will be the responsibility of the Nursing Respite Service Provider and the member.
   B. Nursing Respite services provided by the Private Duty Nursing provider require a physician’s order that includes the scope and duration of service(s). A new physician’s order will be obtained when there is a revision in the service, and/or on an annual basis with the Care Plan renewal. The order must be obtained by the agency providing PDN and shared with the MCO.
   C. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement.
   D. The provider of Nursing Respite Services must maintain a cumulative record of utilization of respite care, to include time used.
   E. The member cannot schedule his or her own respite with the nursing respite staff.
   F. The member may receive a maximum of 100 hours annually per Care Plan year provided there is a primary caregiver.

5. REIMBURSEMENT
   A. Reimbursement is on an hourly unit rate and is accrued to the nearest quarter of an hour. Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
   B. Reimbursement for Nursing Respite services will be based on the current negotiated with the MCO the services. Providers of service have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.
RESPITE SERVICES
Respite services provide the member’s primary caregiver with a limited leave of absence to prevent burnout and provide temporary relief to meet a family crisis, emergency or caregiver’s illness as determined in the 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. It is not necessary for the primary caregiver to reside with the member in order to receive respite services. Respite services may be provided in the member’s home, in the respite provider’s home and in the community. Respite services are limited to a maximum of 100 hours per CCP year. Respite services must not be provided by a member of the member’s household or by any relative approved as the employed caregiver. Respite Services are provided to ABCB members on an episodic basis that enables members to accomplish tasks that they would normally do for themselves if they did not have a disability. Respite services assist the members to maintain the home (or living area occupied by the participant) in a clean and safe environment and assist the member in activities of daily living (ADL). Respite services are provided pursuant to the 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/partial (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;
l. Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or
m. Toileting – Transferring on or off toilet.
n. Skin Care – Observation of skin condition for maintaining good skin integrity and prevention of skin infection, irritation, ulceration or pressure sores.
o. Assisting with Self-Administered Medication – Prompting and Reminding in accordance with the New Mexico Nursing Practice Act. Getting a glass of water or juice as requested if member is not able to do that for himself/herself, handing the member a daily medication box or medication bottle. For the nurse practice act, refer to the PDN service standards.
p. Eating – Assistance with eating as determined in the Care Plan. Individuals requiring tube feeding or J-tube feedings or who are at risk for aspiration are an exception and require specialized care as prescribed by physician.
q. Range of Motion Exercises as described in a Therapeutic Plan developed by therapists and taught to the caregiver and caregiver supervisor by a Physical Therapist or Occupational Therapist.
r. Support Services – Support services provide additional assistance to members in order to promote independence and enhance his or her ability to remain in a clean and safe environment. The following support services will be identified in the assessment of the Instrumental Activities of Daily Living and are provided as determined in the Care Plan:
s. Shopping and/or completing errands for the member, with or without the member; and	u. Accompanying or assisting with non-medical transportation.
2. AGENCY PROVIDER REQUIREMENTS
The respite staff must possess a current New Mexico driver’s license and a Motor vehicle insurance policy if the member is to be transported by the respite staff. Release of Liability Forms must be completed and on file in the member and/or employee’s file. Respite provider agencies are not required to provide transportation services. The MCO Care Coordinator assess the member’s formal and informal support system and determine if other individuals and/or other Medicaid agencies can provide assistance with shopping and transportation services.
A. Service Requirements
   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 (MPPA).

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 (MPPA). Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for respite services will be based on the negotiated rate with the MCOs. Providers of respite services have the responsibility to review and assure that the information on the prior authorization for their services is correct. If the provider identifies an error they will contact the MCO immediately to have the error corrected.

4. LIMITS OR EXCLUSIONS
A. Respite services may not be provided to the member by his or her spouse.
B. Respite services cannot be included in the 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.
D. For children and youth up to 21 years of age diagnosed with a serious emotional or behavioral health disorder, respite services are limited to 720 hours a year or 30 calendar days.

5. AUTHORIZATION OF PERSONAL CARE RESPITE SERVICES
a. Scheduling of hours for use of Respite Services will be the responsibility of the member of service or their representative.

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

c. The provider of Respite Services must maintain a cumulative record of utilization of respite care, to include time used.
d. The member cannot schedule his or her own respite with the respite staff.

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

6. **OTHER**

Under no circumstances may a respite staff act on behalf of a member as their representative in matters regarding medical treatment, financial, legal or budgetary decision-making, and/or manage a member’s finances. An immediate referral must be made to the MCO in order to determine if the member should be referred to an appropriate social service or legal services agency(s) for assistance in these areas.
SKILLED MAINTENANCE THERAPIES
Skilled Maintenance Therapies include Occupational Therapy (OT), Physical Therapy (PT) and Speech and Language Therapy (SLT) for individuals twenty-one years and older. These services are an extension of therapy services provided for acute and temporary conditions that are provided with the expectation that the individual will improve significantly in a reasonable and generally predictable period of time. Skilled Maintenance Therapy services are provided to adults with a focus on maintenance, community integration, socialization and exercise, or enhance support and normalization of family relationships.

1. LIMITS OR EXCLUSIONS
   A signed therapy referral for treatment must be obtained from the member’s primary care physician. The referral will include frequency, estimated duration of therapy, and treatment/procedures to be rendered.
OCCUPATIONAL THERAPY FOR ADULTS
Occupational therapy is a skilled therapy service for individuals 21 years and older provided by a licensed Occupational Therapist. Occupational Therapy services promote/maintain fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. A signed occupational therapy referral for treatment must be obtained from the member’s primary care physician in accordance with state laws and applicable regulations. A copy of the written referral will be maintained in the member’s file by the occupational therapist and shared with the MCO. Children (individuals under the age of 21 receive this service through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT). Specific services may include the following;

1. SCOPE OF SERVICES
   A. Teaching daily living skills;
   B. Developing perceptive 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 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 evalulative 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.
### Agency Based Community Benefit

Services, Service Codes and Applicable Units of Service

<table>
<thead>
<tr>
<th>SERVICE TYPE</th>
<th>CODE</th>
<th>UNIT INCREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health</td>
<td>S5100</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>T2031</td>
<td>Month</td>
</tr>
<tr>
<td>Community Transition Services</td>
<td>T2038</td>
<td>Per service</td>
</tr>
<tr>
<td>Emergency Response</td>
<td>S5161</td>
<td>Month</td>
</tr>
<tr>
<td>Emergency Response High Need</td>
<td>S5161 U1</td>
<td>Month</td>
</tr>
<tr>
<td>Environmental Modifications</td>
<td>S5165</td>
<td>1 unit per project</td>
</tr>
<tr>
<td>Behavior Support Consultation</td>
<td>H2019</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Behavior Support Consultation, Clinic Based</td>
<td>H2019TT</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Employment Supports</td>
<td>H2024</td>
<td>Day</td>
</tr>
<tr>
<td>Home Health Aid</td>
<td>S9122</td>
<td>Hour</td>
</tr>
<tr>
<td>Personal Care-Consumer Directed</td>
<td>99509</td>
<td>Hour</td>
</tr>
<tr>
<td>Personal Care-Consumer Delegated</td>
<td>T1019</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Personal Care under 21</td>
<td>S5125</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Personal Care-Directed training</td>
<td>S5110</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Personal Care-Directed-Administrative Fee</td>
<td>G9006</td>
<td>1 unit + 1 month</td>
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<tr>
<td>Private Duty Nursing for Adults – RN</td>
<td>T1002</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Private Duty Nursing for Adults – LPN</td>
<td>T1003</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Respite RN</td>
<td>T1002 U1</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Respite</td>
<td>T1003 U1</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Physical Therapy for Adults</td>
<td>G0151</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Occupational Therapy for Adults</td>
<td>G0152</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Speech Language Therapy for Adults</td>
<td>G0153</td>
<td>15 minutes</td>
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</table>
9    SELF-DIRECTED COMMUNITY BENEFIT (SDCB)

Revision Dates:    August 15, 2014; February 23, 2015
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 services and supports.

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

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 services, supports and goods they need. SDCB members also decide when, where and how those SDCB services and supports 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 services and supports within a managed care environment. Self-direction means that SDCB members have more choice, control, flexibility, freedom and responsibility.

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” means the individual designated to represent and act on behalf of 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):** Contractor that helps implement the approved SDCB Care Plan by paying the member’s workers and vendors and tracking expenditures. Xerox is the current FMA.

6. **FOCoSonline:** On-line system used by the SDCB FMA for receiving and processing payments. 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 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 nursing facility level of care (NFLOC) for SDCB members. The MCO also performs utilization management duties – review and approval or denial of each individual services/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:** SDHC members who disagree with a decision made by the MCO/UR may submit a written request through a care coordinator/support broker to the MCO/UR for a reconsideration of the decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.

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

13. **SDCB Budget:** The maximum budget allotment available to an eligible SDHC 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 SDHC member will develop a SDHC 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 SDHC services of the SDHC member’s choice; the projected cost, frequency and duration of services and goods; the type of provider who will furnish each service or good; other services and goods to be used by the member. Each SDHC 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 SDHC care plan is mandatory for all SDHC members and must be processed through the FOCoS online system.

15. **SDCB Member:** An individual who meets the medical and financial eligibility and is approved to receive services through the SDHC after having receiving ABCB for a minimum of 120 calendar days.

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

17. **Support Broker (SB):** An individual who provides support to SDHC members and assists the member (or the member’s family or representative, as appropriate) in arranging for, directing and managing SDHC services and supports as well as developing, implementing and monitoring the SDHC 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 SDHC 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 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 can result in termination from the SDCB.

The most basic responsibility of a SDCB member is to maintain his/her financial and medical eligibility to remain in the program. 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. ON-GOING SDCB MEMBER RESPONSIBILITIES INCLUDE
   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 goods covered by the SDCB and only purchasing services and 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 a change in address or hospitalization, which might affect eligibility for the program. Changes in address or other contact
information must also be reported to the 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. Every SDCB member must have an Employer of Record (EOR) who is responsible for directing the work of SDCB employees, and ensuring payment to employees and vendors. 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. A SDCB member’s Power of Attorney may be the EOR but cannot be a paid employee at the same time. If a SDCB member’s Power of Attorney (POA) includes conservatorship over financial matters, the POA shall be the member’s EOR due to the financial responsibilities inherent to 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. 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 an 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 budget amounts spent on paying employees and for approved services and goods. EORs authorize the payment of timesheets and invoices by the Financial Management Agency (FMA). The EOR cannot be a SDCB employee or vendor. The EOR cannot be paid for performing the employer of record functions.

A. The SDCB member/EOR responsibilities include:
   a. Arranging for the delivery of SDCB services, supports and 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 payment to employees and vendors;

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 history record check has been successfully completed, for those crimes determined to be disqualifying convictions as stated in NMSA 1978, Section 29-17-3. The EOR discusses this with the employee and reserves the right to dismiss the employee based on the results of the criminal history record check;

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

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

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 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.

3. 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.
A. 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.

B. Care Coordinator
a. The care coordinator is responsible for managing the member’s acute care, behavioral health care, home and community based services, and long-term care. In SDCB, the care coordinator is primarily responsible for coordinating all aspects of the SDCB member’s care and for determining and submitting the SDCB care plan to the MCO/UR for approval or denial. SDCB related assistance includes, but is not limited to:
   1. Understanding SDCB member and EOR roles and responsibilities;
   2. Identifying resources outside the SDCB, including natural and informal supports, that may assist in meeting the SDCB member’s needs;
   3. Understanding the array of SDCB covered supports, services, and goods;
   4. 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;

b. Providing the support broker with the current and all historical Comprehensive Needs Assessments (CNA) including the Assessor’s individual specific health and safety recommendations;
   1. Monitoring utilization of SDCB services and goods on a regular basis;
   2. Conducting employer-related activities such as completing the EOR self-assessment with the member and informing the FMA of the designated EOR;
   3. Identifying and resolving issues related to the implementation of the SDCB care plan/budget;
   4. 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;
   5. Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;
   6. Monitoring quality of services provided by support brokers; and
   7. Working with the member to provide the necessary assistance for successful SDCB implementation.
C. Support Broker

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

a. 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. 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.

1. The extent of assistance is based upon individual SDCB member needs, and includes, but is not limited to, providing help and guidance to:
   i. Educate members on how to use self-directed supports and services and provide information on program changes or updates;
   ii. Review, monitor and document progress of the member’s SDCB care plan;
   iii. Assist in managing budget expenditures and complete and submit budget revisions;
   iv. Assist with EOR functions such as recruiting, hiring and supervising providers;
   v. Assist with approving/processing job descriptions for direct supports;
   vi. Assist with completing forms related to employees;
   vii. Assist with approving timesheets and purchase orders or invoices for goods, obtaining quotes for services and goods as well as identifying and negotiating with vendors;
   viii. Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;
   ix. Facilitate resolution of any disputes regarding payment to providers for services rendered;
   x. Develop the care plan for SDCB, based on the SDCB budget amount determined by the annual CNA; and
   xi. Assist in completing all documentation required by the FMA.

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

1. Review spending patterns;
2. Review and document progress of SDCB care plan/budget implementation;
3. Document the usage and effectiveness of the SDCB backup plan; and

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

a. The FMA is responsible for providing the following services in the SDCB program:
   1. Assure program compliance with state and federal employment and IRS requirements;
   2. Assist each SDCB member/EOR to set up a unique Employer Identification Number (EIN) if they intend to hire employees;
   3. 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;
   4. Provide all SDCB members with necessary documents, instructions and guidelines;
   5. Collect all documentation necessary to verify that SDCB providers and vendors have the qualifications and credentials required by the SDCB rules;
   6. 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;
   7. 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;
   8. 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;
   9. Process and pay invoices for services and goods that are approved in the SDCB member’s care plan, when supported by required documentation;
   10. Handle all payroll functions on behalf of the SDCB members who hire direct service employees and other support personnel, including collecting and processing timesheets of support workers, processing payroll, withholding, filing and payment of
applicable federal, state and local employment-related taxes and insurances;

11. 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

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

b. FOCoSonline

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

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

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

4. 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.

4. PLANNING AND BUDGETING FOR SDCB SERVICES AND GOODS

A. SDCB Care Plan Development Processes

The SDCB care plan development process starts with person-centered planning. In person-centered planning, the SDCB care plan must revolve around the individual SDCB member and reflect his/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 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 planning process. The
SDCB care plan is entered into FOCoS online by the support broker.

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

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

The SDCB care plan 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 FOCoS online, that
the member’s SDCB care plan is ready for review and submission. After
reviewing the SDCB care plan, the care coordinator will submit it in
FOCoS online to the MCO/UR for review and approval or denial using
FOCoS online. 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.

B. 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.

C. 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, Appendix C.);
  c. Schedule the provision of 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 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 employees and service
     providers complete all FMA required paperwork, including a criminal
     background check when necessary. Payment for approved SDCB services
and goods cannot be made until all necessary and required paperwork is successfully complete 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. Approve payment, according to the SDCB care plan, for approved SDCB services and 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.

j. Additionally, the SDCB members:
   1. Cannot/will not be reimbursed directly for any SDCB services, supports and/or goods;
   2. Must follow the SDCB care plan as approved;
   3. 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
   4. Shall be accountable for the use of all SDCB funds.

5. 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 or vendor enrollment packet, specific to the SDCB provider or vendor type, for approval to the FMA.

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

A. General qualifications for SDCB individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies who are employed by a SDCB member 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 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 NMAC); and

h. maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

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

a. be qualified to provide the service;

b. possess a valid business license, if applicable;

c. 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;

d. if a support broker provider, meet all of the qualifications set forth in 8.308.12 NMAC;

e. if a currently approved SDCB provider, be in good standing with the appropriate state agency;

f. meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and

g. maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

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

a. LRIs, e.g., the parent (biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a SDCB member, may be hired and paid for the provision of SDCB 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 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.

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.

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

D. Services provided by LRIs must:

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

6. ONGOING SUPPORT BROKER SERVICES

A. Definition of Service

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

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

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

B. Scope of Service

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

1. 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 (ABCB);
2. Assist SDCB members to transition from/to ABCB/SDCB. Transition from and to ABCB/SDCB can only occur at the first of the month;
3. Provide the member with information, support and assistance during the annual Medicaid eligibility processes, including the annual CNA and the annual medical/financial eligibility processes;
4. Assist existing members with annual LOC requirements within ninety (90) calendar days prior to the expiration of the LOC; and
5. 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:
   a. General program overview including key agencies and contact information;
   b. Discuss eligibility requirements and offer assistance in completing these requirements as needed;
   c. Discuss SDCB member roles and responsibilities;
   d. Discuss the EOR roles and responsibilities;
e. Review the processes for hiring SDCB employees and contractors and required paperwork;

f. Review the process and paperwork for hiring Legally Responsible Individuals (LRI) as employees;

g. Discuss the background check and other credentialing requirements for SDCB employees and contractors; and

h. Referral for accessing training for the FOCoS online system; and to obtain information on the Financial Management Agency (FMA).

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

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

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

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

10. Assist the SDCB member to identify resources outside the SDCB that may assist in meeting his/her needs.

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

12. Assist SDCB members with the Environmental Modification process;

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

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

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

16. Assist SDCB members to transition to another support broker agency when requested. Transitions should occur within 30 calendar days of SDCB member’s written request, but may occur sooner based on the needs of the SDCB member. Transition from one support broker agency to another can only occur at the first of the month; and

17. Assist SDCB members to identify and resolve issues related to the implementation of the SDCB care plan.

b. Support Brokers must ensure that the SDCB care plan for each member is submitted in the appropriate format as prescribed by the state, using the FOCoS online system, and includes the following:
a. The services and supports, covered by the SDCB, to address the needs of the member as determined through the CNA and person-centered planning process;

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

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

c. 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 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. The support broker agency shall provide training to members related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and member deaths. This 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).

C. Support Broker Functions

Support brokers shall make contact with the SDCB member at least monthly for a routine follow up. This contact can either be face to face or by telephone.

Support Brokers shall meet in person with the SDCB member at a minimum of once each quarter. It is mandatory that a minimum of one (1) visit per SDCB care plan year is to be held in the SDCB member’s residence.

The quarterly visits are for the following purposes:

a. Review and document progress on implementation of the SDCB care plan;

b. Document any usage and the effectiveness of the 24-hour backup plan;

c. Review SDCB care plan and budget spending patterns (over and under utilization);

d. Document the SDCB member’s access to related goods identified 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 support(s) as identified in the SDCB care plan; and

f. Identify other concerns or challenges as noted by the member/representative.
D. Critical Incident Management Responsibilities and Reporting Requirements
   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.
   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.
   e. Critical incident reporting requirements: All incident reports for the Home and Community Based and Behavioral Health Services population involving Abuse, Neglect, Self-Neglect, Exploitation, Environmental Hazard, Law Enforcement Involvement, and Emergency Services, must be reported to the member’s MCO Care Coordinator, Support Broker and/or Adult Protective Services (APS).

E. Administrative Requirements
   a. 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:
      1. Have a current business license issued by the state, county, or city government as required;
      2. Maintain financial solvency;
      3. 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;
      4. Ensure that all employees are trained and competent in the use of the FMA and FOCosonline system;
      5. 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
      6. Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.
b. 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.

c. 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:

1. The support broker agency must maintain a presence in each region for which they are providing services;
2. 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;
3. 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;
4. 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);
5. The support broker agency must maintain an operational fax machine at all times; and
6. The support broker agency must maintain an operational email address, internet access, and the necessary technology to access SDCB related systems.

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

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

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

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

h. The support broker agency shall maintain HIPAA compliant primary records for each SDCB member including, but not limited to:

1. Current and historical SDCB care plan and budget;
2. Contact log that documents all communication with the SDCB member;
3. Completed/signed quarterly visit form(s);
4. MCO/UR documentation of approvals/denials, including SDCB care plan and revision requests;
5. MCO/UR correspondence; (requests for additional information, etc);
6. Copy of current and all historical Comprehensive Needs Assessment (CNA) including the Assessor’s individual specific health and safety recommendations;
7. Notifications of medical and financial eligibility;
8. SDCB budget utilization reports from the FMA;
9. Environmental Modification approvals/denials;
10. Legally Responsible Individual (LRI) approvals/denials;
11. Documentation of SDCB member and employee incident management training;
12. Copy of legal guardianship or representative papers and other pertinent legal designations; and
13. 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:
   1. Be at least 18 years of age;
   2. Possess a minimum of a Bachelor’s degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;
   3. Have one (1) year of supervised experience working with seniors and/or people living with disabilities;
   4. Complete all required SDCB orientation and training courses; and
   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; or

b. Support broker providers shall:
   1. Be at least 18 years of age;
   2. 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;
   3. Be employed by an enrolled support broker agency;
   4. Complete all required SDCB orientation and training courses; and
   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.

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.
7. SDCB COVERED SERVICES
   A. All SDCB services are subject to the approval of the MCO/UR. Below is a list of SDCB covered services and goods for members in SDCB, followed by a detailed service description:
      a. Behavior Support Consultation Services
      b. Customized Community Support
      c. Emergency Response
      d. Employment Supports
      e. Environmental Modifications
      f. Home Health Aide
      g. Homemaker/Direct Support
      h. Nutritional Counseling
      i. Private Duty Nursing
      j. Related Goods
      k. Respite
      l. Skilled Therapy Services for Adults
      m. Specialized Therapies
      n. Transportation (Non-Medical)
   B. Descriptions for each of the above SDCB covered services.
      a. BEHAVIOR SUPPORT CONSULTATION SERVICES
         1. 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.
         2. 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.
         3. Behavior Support Consultant Qualifications – Individual:
            i. Provide a tax identification number;
            ii. Maintain a member file within HIPAA guidelines to include:
a. Member’s SDCB care plan;
b. Reports as requested in the SDCB care plan;
c. Contact notes; and
d. 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:
  a. Medical doctor (M.D.);
  b. Licensed clinical psychologist;
  c. Licensed psychologist associate (masters or PhD level);
  d. Licensed social worker (LISW or LMSW);
  e. Licensed professional clinical counselor (LPCC);
  f. Licensed professional counselor (LPC);
  g. Licensed psychiatric nurse (MSN/RNSC);
  h. Licensed marriage and family therapist (LMFT); or
  i. Licensed practicing art therapist (LPAT).

4. Behavior Support Consultant Qualifications - Provider Agency:
   a. Provide a tax identification number; and current business license issued by state, county or city government, if required.
   b. Maintain a member file within HIPAA guidelines to include:
      1. Member’s SDCB care plan;
      2. Reports as requested in the SDCB care plan;
      3. Contact notes; and
      4. Training roster(s).
   c. Ensure therapists have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
      1. Medical doctor (M.D.);
      2. Licensed clinical psychologist;
      3. Licensed psychologist associate (masters or PhD level);
      4. Licensed social worker (LISW or LMSW);
      5. Licensed professional clinical counselor (LPCC);
      6. Licensed professional counselor (LPC);
      7. Licensed psychiatric nurse (MSN/RNSC);
      8. Licensed marriage and family therapist (LMFT); or
      9. Licensed practicing art therapist (LPAT).
b. CUSTOMIZED COMMUNITY SUPPORTS

1. 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.

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

2. Scope of Services

Customized Community Support services include, but are not limited to the following:

i. Provide supports in congregate and community day programs that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills;

ii. Adult day health services;

iii. Adult day habilitation services; and

iv. Other day support model services.

3. 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:

   a. Be at least 18 years of age;

   b. Have at least one (1) year of experience working with people with disabilities;

   c. Be qualified to perform the service and demonstrate capacity to perform required tasks;
d. Be able to communicate successfully with the member;

e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

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

g. 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

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

c. EMERGENCY RESPONSE

1. 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.

2. 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.

3. 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

1. 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. Employment Supports cannot duplicate any other SDCB service. Employment Supports include two 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. The SDCB member must exhaust all available vocational rehabilitation supports prior to requesting Employment Supports on their SDCB care plan.

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.

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.

2. 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 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 members when the services are not otherwise available for the member under a program funded under the Rehabilitation Act of 1973, the Division of Vocational Rehabilitation or through the New Mexico Department of
Education. Job development is a service provided to members by skilled staff. The service has five components: job identification and development activities; employer negotiations; job restructuring; job sampling; and job placement.

3. 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 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;
xi. 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
sv. Adherence to rules of the specific work place, including dress, confidentiality, safety rules and other areas required by the employer.

4. 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 Labor Navigators, One-Stop Career Centers, Department of Labor, Business Leadership Network, Chamber of Commerce, Job Accommodation Network, Small Business Development Centers, Retired Executive, Businesses, community agencies, and the NM Employment Institute to achieve employment outcomes;
   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. 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.

5. 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.

6. 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:
   a. Department of Workforce Solutions Navigators;
   b. One-Stop Career Centers;
   c. Business Leadership Network;
   d. Chamber of Commerce;
   e. Job Accommodation Network;
   f. Small Business Development Centers;
   g. Retired Executives; and
   h. New Mexico Employment Institute.

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.

7. 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:
   a. Be at least 18 years of age;
b. Be qualified to perform the service and demonstrate capacity to perform required tasks;
c. Be able to communicate successfully with the member;
d. Experience as a job coach for at least one year;
e. Experience for at least one year using job and task analyses;
f. Trained on American with Disabilities Act (ADA);
g. Trained on the purpose, function and general practices of the Division of Vocational Rehabilitation (DVR);
h. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
i. Complete training on critical incident, abuse, neglect, and exploitation reporting;
j. Complete member specific training; the evaluation of training needs is determined by the member or his/her legal representative; member is also responsible for providing and arranging for provider training and supervising provider performance; training expenses for paid providers cannot be paid for with the SDCB member’s annual budget; and
k. Meet any other service qualifications, as specified in the SDCB rules.

8. 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:
      i. Department of Workforce Solutions Navigators;
      ii. One-Stop Career Centers;
      iii. Business Leadership Network;
      iv. Chamber of Commerce;
      v. Job Accommodation Network;
      vi. Small Business Development Centers;
      vii. Retired Executives; and
      viii. 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

1. 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 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.

Because the MCO is the payer of last resort, the MCO shall first consider alternative methods of meeting the individual’s needs. This would include insurance, workman’s compensation,
vocational rehabilitation, volunteer organizations, etc. The MCO must include documentation that all other viable resources to fund the proposed modification have been exhausted, or contacted and refused. Environmental Modifications will not be reimbursed from any other SDCB service code.

2. 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 and/or signaling devices.

3. 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.

4. The Environmental Modification provider must:
   i. Provide a (1) one-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 to ensure that the adaptations meet the approved plan submitted for environmental adaptation; and

iv. Provider must establish and maintain financial reporting and accounting for each member.

5. 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 member;
   iv. Letter of Permission from property owner. If the property owner is someone other than the member, the letter must be signed by the property owner and the member;
   v. The Construction Letter of Understanding. If the property owner is someone other than the member, the letter must be signed by the property owner and the member; and
   vi. Documentation demonstrating compliance with the Americans with Disabilities Act (ADA).

6. 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 member;
   ii. Photographs of the completed modifications.

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

8. Reimbursement
   Environmental Modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (MPPA). Billing is on a project basis, one (1) unit per Environmental Modification project. Reimbursement for Environmental Modification services will be based on the negotiated rate with the MCOs.

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 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
1. 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.

2. 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.

3. 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:

a. Be at least 18 years of age;

b. Be qualified to perform the service and demonstrate capacity to perform required tasks;

c. 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;
d. Be able to communicate successfully with the member;

e. Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;

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

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

**HOMEMAKER/DIRECT SUPPORT**

1. 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 guidelines. Two (2) or more SDCB members living in the same residence, who are receiving services and supports under SDCB will be assessed both independently and jointly to determine coverage of services and supports that are shared. Services and supports will be approved based on common needs and individual needs.

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

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

2. Scope of Services

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;
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.

3. 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;
   v. Complete training on critical incident, abuse, neglect, and exploitation reporting;
   vi. 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
   vii. Meet any other service qualifications, as specified in the SDCB rules.

4. 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:
        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; 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
g. Meet any other service qualifications, as specified in the SDCB rules and Managed Care Policy Manual.

h. NUTRITIONAL COUNSELING
   1. 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.
   2. 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.
   3. 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.
   4. 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
   1. 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.
   2. 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;
viii. Wound care;
ix. Health education and screening;
x. Infection control;
xi. Environmental management for safety;
(xii. Nutrition management;

xiii. Oxygen management;
xiv. Seizure management and precautions;
xv. Anxiety reduction;
xvi. Staff supervision; and
xvii. Behavior and self-care assistance.

3. PRIVATE DUTY NURSING QUALIFICATIONS – AGENCY PROVIDER

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;
xii. Be able to communicate successfully with the member;
xiii. Complete training on critical incident, abuse, neglect, and exploitation reporting;
xiv. Individual RN/LPN providers must be licensed by the New Mexico state board of nursing as an RN or LPN; and
xv. Meet any other service qualifications, as specified in the SDCB rules.

4. PRIVATE DUTY NURSING QUALIFICATIONS – INDIVIDUAL PROVIDER

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

1. Definition of Service
   Related Goods are equipment, supplies, fees (such as for conferences or classes) or memberships, not otherwise provided through SDCB, the Medicaid state plan or through Medicare. Related goods do not include services such as housecleaning, yard maintenance, personal trainers, etc.

   Related goods must be documented in the SDCB care plan, and be approved by the MCO/UR. The cost and type of related good is subject to approval by the MCO/UR. 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.

   The related goods must not be available through another source and the SDCB member must not have the personal funds needed to purchase the goods.

   Experimental or prohibited treatments and goods are excluded

2. Scope of Services
   Related Goods must address a need identified in the member’s CNA (including improving and maintaining the member’s opportunities for full membership in the community) and meet the following requirements as appropriate:
   i. Be responsive to the SDCB member’s qualifying condition or disability; and
   ii. Meet the SDCB member’s clinical, functional, medical or habilitative needs; and
   iii. Support the SDCB member to remain in the community and reduce the risk for institutionalization; and
   iv. Decrease the need for other Medicaid services; and
   v. Advance the desired outcomes in the SDCB member’s care plan; and
   vi. Promote personal safety and health; and
vii. Afford the SDCB member an accommodation for greater independence; and/or
viii. Accommodate the SDCB member in managing his/her household; and/or
ix. Facilitate activities of daily living.
3. Related Goods Qualifications - Vendor Agency Provider:
   i. Valid tax identification for the state and federal governments.

k. RESPITE
   1. Definition of Service
      Respite is a flexible family support service that provides support to the SDCB member and gives the primary unpaid caregiver time away from his/her duties. Respite services are used to allow the SDCB member’s unpaid primary caregiver a limited leave of absence in order to reduce stress, accommodate caregiver illness, or meet a sudden family crisis or emergency. Respite services are furnished on a short term basis and 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.

   2. Scope of Services
      Respite services include, but are not limited to the following:
      i. Respite services are limited to a maximum of 100 hours annually per care plan year provided there is a primary unpaid provider. 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.

3. 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.

4. 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:
       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 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;

g. Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN; and

h. Meet any other service qualifications, as specified in the SDCB rules and Managed Care Policy Manual.

1. SKILLED MAINTENANCE THERAPIES SERVICES

1. 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. 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.

iv. 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.
2. Scope of Services
   i. Physical Therapy:
      a. Diagnostic activities to determine the dysfunction of physical and functional activities;
      b. Activities to increase, maintain or reduce the loss of functional skills;
      c. Treat specific condition(s) clinically related an SDCB member’s qualifying condition or disability;
      d. Activities to support the SDCB member’s health and safety needs; and
      e. 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
      a. Diagnostic activities to determine skills assessment and treatment;
      b. Write treatment program to improve one’s ability to perform daily tasks;
      c. Comprehensive home, employment and/or volunteer sites evaluations with adaptation recommendations;
      d. Provide guidance to family members and caregivers;
      e. Make assistive technology recommendations and provide usage training for SDCB members, family and staff; and
      f. 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
      a. Improve or maintain the SDCB member’s capacity for successful communication or to lessen the effects of the member’s loss of communication skills;
      b. Consultation on usage and training on augmentative communication devices;
      c. 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
      d. 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
   a. Provide a tax identification number.
   b. Maintain a case file within HIPAA guidelines for the SDCB member to include:
      1. SDCB member’s SDCB care plan;
      2. Reports as requested in the SDCB care plan;
      3. Contact notes;
      4. Training roster(s); and
      5. Assessments for Environmental Modification requests.
   c. Licensures:
      1. Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq.;
      2. Occupational therapists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A-1et.seq.; and
      3. Speech and Language Pathologists will be licensed as per the New Mexico Regulation and Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-14B-1et.seq.

v. Therapy Qualifications – Provider Agency
   a. Current business license;
   b. Provide tax identification number;
   c. Ensure physical therapists maintain a case file within HIPAA guidelines for the SDCB member to include:
      1. SDCB member’s SDCB care plan;
      2. Reports as requested in the SDCB care plan;
      3. Contact notes;
      4. Training roster(s); and
      5. Assessments for Environmental Modification requests.
   d. Ensure therapists has appropriate license for service
      1. Physical therapists will be licensed as per the New Mexico Regulation and Licensing Department; Physical Therapy Act NMSA 1978, Section 61-12-1.1 et.seq.;
      2. Occupational therapists will be licensed as per the New Mexico Regulation and
m. SPECIALIZED THERAPIES SERVICES

1. 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 (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.

2. 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.

vii. **Naprapathy** focuses on the evaluation and treatment of neuro-musculoskeletal conditions and is a system for restoring functionality and reducing pain in muscles and joints. The therapy uses manipulation and mobilization of the spine and joints and muscle treatments such as stretching and massage. Based on the concept that constricted connective tissue (ligaments, muscles and tendons) interfere with nerve, blood and lymph flow, naprapathy uses manipulation of connective tissue to open these channels of body function. See Naprapathic Practitioners 16.6.1 NMAC.

viii. **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.

3. **Specialized Therapy Qualifications – Individual Therapist Provider**
   i. Current New Mexico state license as applicable:
      a. Acupuncture and Oriental Medicine license
      b. Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.
      c. Chiropractic Physician license
      d. 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.
e. Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy and appropriate specialized training and experience.

f. Massage therapy license

g. Naprapathic Physician license

h. 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.

4. 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:

a. Acupuncture and Oriental Medicine license

b. Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision.

c. Chiropractic Physician license

d. 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.

e. Hippotherapy – license in a health care profession whose scope of practice includes hippotherapy and appropriate specialized training and experience.

f. Massage therapy license

g. Naprapathic Physician license

h. Native American Healers – individuals who are recognized as healers within their communities.

n. TRANSPORTATION (NON-MEDICAL)

1. 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 local area, within a 50 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 vacation is not covered through the SDCB Program.

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. 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.

2. 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.

3. 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;
   vi. 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.

4. 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.

C. SELF-DIRECTED NON-COVERED SERVICES

All SDCB services are subject to the approval of the MCO/UR.

When a SDCB member requests a non-covered service or good, the support broker and/or care coordinator shall work with the member to find other (including less costly) alternatives.

a. Services and goods that are not covered by the SDCB program include, but are not limited to the following:
b. Services covered by third-parties. The SDCB Program is the payer of last resort;
c. 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;
d. Formal academic degrees or certification-seeking education, educational services covered by IDEA or vocational training provided by the Division of Vocational Rehabilitation (DVR);
e. Room and board, meaning shelter expenses, including property-related costs, such as rental or purchase of real estate and furnishing(s), home and property maintenance, utilities and utility deposits, and related administrative expenses. Utilities include gas, electricity, propane, firewood, wood pellets, water, sewer, and waste management;
f. Experimental or investigational services, procedures or goods, as defined in 8.325.6 NMAC;
g. Any goods or services that a household that does not include a person with a disability would be expected to pay for as a routine household expense;
h. Any goods or services that are to be used for recreational or diversional purposes;
i. Personal goods or items not related to the SDCB member’s condition or disability;
j. 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;
k. Gas cards and gift cards. Items that are purchased with SDCB program funds may not be returned for store credit, cash or gift cards;
l. Purchase of insurance, such as car, health, life, burial, renters, homeowners, service warrantees or other such policies. This includes purchase of cell phone insurance;
m. Purchase of a vehicle, and long-term lease or rental of a vehicle;
n. Purchase of recreational vehicles, such as motorcycles, campers, boats or other similar items;
o. Firearms, ammunition or any other type of weapons;
p. Gambling, games of chance (such as bingo or lottery), alcohol, tobacco, or similar items;
q. Vacation expenses, including airline tickets, cruise ship or other means of transport, guided tours, meals, hotel, lodging or similar recreational expenses. This also includes mileage or driver time reimbursement for vacation travel by automobile;
r. Purchase of usual and customary furniture and home furnishings, unless adapted to the SDCB member’s disability or use, or of specialized benefit to the SDCB member’s condition. Requests for adapted or specialized furniture or furnishings must include a doctor’s order from the member’s health care provider and, when appropriate, a denial of payment from any other source;
s. Regularly scheduled upkeep, maintenance and repairs of a home and addition of fences, storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the SDCB member’s qualifying condition or disability;
t. Regularly scheduled upkeep, maintenance and repairs of a vehicle, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the SDCB member’s qualifying condition or disability. Requests must include documentation that the adapted vehicle is the SDCB member’s primary means of transportation;
u. Clothing and accessories, except specialized clothing based on the SDCB member’s disability or condition;
v. Training expenses for paid employees;
w. Conference or class fees may be covered for SDCB members or unpaid caregivers, but costs associated with such conferences or classes cannot be covered, including airfare, lodging or meals;
x. For consumer electronics such as computers, printers and fax machines, or other electronic equipment, no more than one (1) of each type of item may be purchased at one (1) time, and consumer electronics may not be replaced more frequently than once every three (3) years. This policy also applies to members who transition from Mi Via to the SDCB. Laptops or any electronic tablets and iPads are considered computers;
y. Cell phone services that include fees for data (to include GPS) or more than one (1) cell phone per SDCB member. SDCB may cover the cost of
text messaging if it is documented and determined that the need for texting is related to the SDCB member’s disability; and

z. Moving expenses to include, but not limited to, the cost of moving truck rental, gas/mileage, labor, moving equipment, supplies, boxes, tape and moving blankets.

D. 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.

E. 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. If the CNA identifies needs for services that are not covered in ABCB, the SDCB member may include them on the SDCB care plan, however the cost for these services/goods in SDCB are not calculated into the SDCB budget determination. This applies to initial and annual SDCB budgets. The care coordinator shall provide the support broker with the SDCB budget amount. The initial 12-month SDCB budget shall be pro-rated based on the number of months already completed in the ABCB. 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 SDCB budget amount, pro-rated or annual, is not an appealable decision because community benefits have not been denied; a determination of the total cost of the ABCB services identified in the CNA is the maximum SDCB budget a SDCB member shall be allocated. The SDCB member may request a new CNA if the SDCB member thinks his/her needs were not adequately addressed in the initial CNA.

F. 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 approved by the MCO/UR and written notification must be sent to the SDCB member before any SDCB services may be utilized and 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 denial decision.

The FMA will utilize the approved SDCB care plan/budget to process payment for the approved amount of SDCB services and 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 goods which are provided or purchased prior to the approval of 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.
G. 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 FOCoS online, 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 FOCoS online, allowing the member and support broker to begin developing the upcoming year’s SDCB care plan.

H. 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 FOCoS online 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).

I. SDCB BUDGET AND CARE PLAN APPROVAL PROCESS FOR INDIVIDUALS WHO TRANSITIONED (GRANDFATHERED) FROM THE MI VIA WAIVER PROGRAM
a. For individuals who had an approved service on their Mi Via Service and Support Plan (SSP) with an approved employee/vendor reimbursement rate above the ABCB reimbursement rate, the Care Coordinator must ensure the SDCB member has the necessary SDCB budget available to continue to reimburse current SDCB employee(s) at the currently approved SDCB reimbursement rate.

Example: Homemaker Service approved by Mi Via Third Party Assessor (TPA) for two (2) employees, each at $14.00 per hour (including Employer Tax Burden (ETB) and Workers Compensation (WC)), 20 hours per week for an annual total of 2080 Homemaker hours at a total of $29,120. The annual MCO CNA results determine that the member
requires 40 hours of Personal Care Service (PCS); PCS in ABCB is reimbursable at $12.35 per hour totaling $25,688. The higher amount of $29,120 must be included in the overall SDCB budget total to allow the SDCB member to continue the current SDCB employee reimbursement rate of $14.00 per hour.

Care Coordinators shall follow the above process for all other services approved in the SDCB member’s care plan when the member transitions from the Mi Via Waiver program to the SDCB. This process must also be completed annually for each member who transitioned from the Mi Via Waiver program directly to the SDCB, until the member’s SDCB eligibility expires.

b. For individuals who had an approved service on their Mi Via SSP with an approved employee/vendor reimbursement rate below the ABCB reimbursement rate, the Care Coordinator must utilize the current ABCB reimbursement rate.

Example: Homemaker Service approved by Mi Via TPA for two (2) employees, each at $11.50 per hour/40 hours per week for an annual total of 4160 Homemaker hours at a total of $47,840; PCS in ABCB is reimbursable at $12.35 per hour totaling $51,376. The higher amount of $51,376 must be included in the overall SDCB budget total. This will allow the SDCB member to purchase additional SDCB covered services, or possibly increase the reimbursement rate for the employee(s).

Care Coordinators shall follow the above process for all other SDCB covered services approved in the SDCB member’s care plan when the member transitions from the Mi Via Waiver program to the SDCB. This process must also be completed annually for each member who transitioned from the Mi Via Waiver program directly to the SDCB, until the member’s SDCB eligibility expires.

c. 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 (Appendix C) 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).

d. 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. These amounts shall be added to the SDCB budget of the assessed ABCB services.

e. 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 80 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.

f. If overutilization of the SDCB care plan/budget is identified at any time during the SDCB care plan/budget 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) 60 percent of the SDCB budget by the end of quarter three of the SDCB member’s current care plan year, or 3) 75 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.

J. DENIALS, REVISIONS AND RECONSIDERATIONS OF THE SDCB CARE PLAN

a. 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.

b. 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.

**c. 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 goods.

K. SDCB CARE PLAN REVIEW CRITERIA
Services and related goods identified in the SDCB member’s requested SDCB care plan may be considered for approval if all the following requirements are met:

a. The SDCB services or goods must be responsive and directly related to the SDCB member’s qualifying condition or disability; and
b. The SDCB services or goods must address the SDCB member’s clinical, functional, medical or habilitative needs; and
c. The SDCB services or goods must accommodate the SDCB member in managing his/her household; and
d. The SDCB services or goods must facilitate activities of daily living; and
e. The SDCB services or goods must promote the SDCB member’s personal health and safety; and
f. The SDCB services or goods must afford the SDCB member an accommodation for greater independence; and
g. The SDCB services or goods must support the SDCB member to remain in the community and reduce his/her risk for institutionalization; and
h. The SDCB services or 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
i. The SDCB service or good is not prohibited by federal and state statutes, rules and guidance; and
j. Each SDCB service or good must be listed as an individual line item; when services or goods must be ‘bundled’ the SDCB care plan must document why bundling is necessary and appropriate; and
k. The proposed SDCB care plan is within the SDCB member’s approved budget; and
l. The proposed rate for each SDCB service is within the SDCB range of rates (Appendix C) for that chosen service; and
m. The proposed cost for each SDCB good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
n. The estimated cost of the SDCB service or good is specifically documented in the SDCB member’s SDCB care plan.

L. IMPLEMENTATION OF THE SDCB CARE PLAN
a. Enrolling SDCB Employees and Vendors
   1. 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.

2. 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 Appendix D & E (Vendor and Employee Credentialing Requirements).
3. 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.

4. For potential SDCB employees, the required documents are included in the Employee Packet:
   i. Employment Agreement
   ii. Employee Information Form
   iii. Declaration of Relationship form
   iv. Federal W-4
   v. State W-4

5. For potential SDCB vendors who are providing services the required documents are included as part of the Vendor Packet:
   i. Vendor Agreement
   ii. Vendor Information Form
   iii. Federal W-9

6. Vendors who are providing SDCB 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.

7. Direct Deposit is provided and strongly recommended for all employees and vendors when possible. The FMA also offers the service of providing payment through a ComData Card. Please contact the FMA if interested in using this service. Direct deposit forms can be completed as part of the initial hire documentation, or may be completed and submitted to the FMA at a later date.

b. Purchasing Services and Goods
1. 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.

2. Invoices
Vendor Payment Request Forms (PRF) (Appendix F) and invoices may be submitted to the FMA on any day of the week (unlike timesheets which must be submitted according to the payroll schedule). The processing time for a PRF/invoice is approximately two (2) weeks. 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 to the FMA for processing. However, 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.

3. 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.

4. **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.

5. **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.

*Managed Care Policy Manual  as of March 3, 2015*
c. SDCB Care Plan Expenditure Safeguards
The SDCB member holds the primary responsibility for monitoring and ensuring that his/her approved SDCB care plan is spent appropriately; however, the care coordinator 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 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 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.

M. TRANSITIONS, TERMINATION AND REINSTATEMENT PROCESSES

a. 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 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:

1. 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 get 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.

2. 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.

3. 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.

b. 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 month.
c. Involuntary Termination

SDCB members may be involuntarily terminated from SDCB and offered services through the ABCB under any of the following circumstances:

1. 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;

2. 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:
   i. The SDCB member refuses to include and maintain services in his/her SDCB care plan that would address health and safety issues identified in his/her medical assessment or challenges the assessment after repeated and focused technical assistance and support from program staff, care coordinator/support broker, or FMA;
   ii. 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;
   iii. The SDCB member misuses SDCB funds following repeated and focused technical assistance and support from the care coordinator/support broker or FMA, which is supported by documentation;
   iv. The SDCB member expends his/her entire SDCB budget prior to the end of the SDCB care plan year; or
   v. The SDCB member commits Medicaid fraud such as, for example, altering SDCB employee/vendor payment checks.

3. 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 termination, in writing, and shall include appeal rights per HSD rules.
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.

1. 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.

2. 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:
Appendix C: Range of Rates and Service Codes
Appendix D: Vendor Credentialing Requirements Grid
Appendix E: Employee Credentialing Requirements Grid
Appendix F: Vendor Payment Request Forms (PRF)
Appendix G: Toolkit: Vendor
Appendix H: Toolkit: Employee
Appendix I: Employer of Record (EOR) Self-Assessment
Appendix J: List of SDCB Acronyms
Appendix P: Naming Convention for FOCoSonline

Managed Care Policy Manual as of March 3, 2015
### APPENDIX C: SDCB RANGE OF RATES CHART

SDCB rates are to be provided to the MCOs by 5/31/13

<table>
<thead>
<tr>
<th>SDCB SERVICE</th>
<th>BILLING CODE</th>
<th>INTERNAL 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 –Adults</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>-----------------------------</td>
<td>-------</td>
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<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>
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<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 (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CE-I</td>
<td>Each</td>
<td>As approved by MCO</td>
</tr>
<tr>
<td>Coaching/education for parents, spouse or others-classes only (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CL-I</td>
<td>Each</td>
<td>As approved by MCO</td>
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<tr>
<td>Coaching/education for parents, spouse or others-conferences and seminars (not available for paid caregivers)</td>
<td>T1999</td>
<td>T1999CS-I</td>
<td>Each</td>
<td>As approved by MCO</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</td>
<td>T1999</td>
<td>T1999CELL</td>
<td>Each</td>
<td>As approved by MCO</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>
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<tr>
<td>Internet/landline</td>
<td>T1999</td>
<td>T1999IL</td>
<td>Each</td>
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<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>
APPENDIX D: SDCB VENDOR CREDENTIALING REQUIREMENTS

Requirements for enrolling Self-Directed Community Benefit (SDCB) Vendors

Before using any Vendor, please call Xerox (1-866-916-0310) to make sure all required vendor paperwork has been processed and that the vendor has been set up on your SDCB Care Plan. If you use a vendor before their paperwork has been processed, they will not be paid for those dates.

All enrollment requirements (with the exception of the final criminal background check) must be processed before services can be provided. Services that are provided prior to enrollment will not be paid by Medicaid or Xerox.

If a vendor provides only goods (not services), you will only need to complete the Vendor Information Form (you do not need to complete the entire Vendor Packet). We use the Vendor Information Form (VIF) to show that you will be using this vendor on your Plan. Since vendors that provide goods are usually large companies (for example: CenturyLink, Comcast, Wal-mart, K-Mart, Best Buy), it is not necessary to get their signature on the form. If you are not sure if what you want to purchase is a “good” or a “service,” please call Xerox for assistance.

<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>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IC: Yes</td>
<td>IC: Acupuncture and/or oriental medicine license</td>
</tr>
<tr>
<td>H2019</td>
<td>Behavior Support Consultation</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td>Individual Behavior Support Consultant (BSC) or BSC Group Practice</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Licensed (MD, Clinical Psychologist, Psychologist Associate, SW, LPCC, LPC, Psychiatric Nurse, NM licensed marriage and family therapist, NM licensed art therapist)</td>
</tr>
<tr>
<td>90901</td>
<td>Biofeedback</td>
<td>Visit</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IC: Yes</td>
<td>IC: License in Health Care Profession whose scope of practice includes Biofeedback</td>
</tr>
<tr>
<td>98940</td>
<td>Chiropractic</td>
<td>Visit</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IC: Yes</td>
<td>IC: Chiropractic Physician License</td>
</tr>
<tr>
<td>T1999CE-I</td>
<td>Coaching Education for Parents, Spouse or Other</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Pre-Hire Packet</td>
</tr>
<tr>
<td>T1999CS-I</td>
<td>Coaching Education for Parents/Spouse: Conferences and Seminars ONLY</td>
<td>Each</td>
<td>Agency: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td></td>
<td>Allowed Providers: Vendor</td>
<td></td>
<td>IC: Yes</td>
<td></td>
</tr>
<tr>
<td>Service Code</td>
<td>Service Code Description</td>
<td>Billing Method</td>
<td>Vendor Packet</td>
<td>License and/or Additional Requirements</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>T1999CL-I</td>
<td>Coaching Education for Parents/Spouse: Classes ONLY Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: 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 IC: Yes</td>
<td>Agency: Business License IC: License in Health Care Profession whose scope of practice includes Cognitive Rehab Therapy</td>
</tr>
<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>
</tr>
<tr>
<td>T1999CP-I</td>
<td>Fees and Memberships Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td>T1999HR-I</td>
<td>Health-Related Equipment &amp; Supplies Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td>T1999AE-I</td>
<td>Adaptive Equipment and Supplies Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td>T1999EE-I</td>
<td>Exercise Equipment and Related Items Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<tr>
<td>T1999NS-I</td>
<td>Nutritional Supplements Allowed Providers: Vendor</td>
<td>Each</td>
<td>Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
</tr>
<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>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------</td>
<td>----------------</td>
<td>---------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>T1999OM-I</td>
<td>Over-the-Counter Medications</td>
<td>Each Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
<td></td>
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<tr>
<td>S9122</td>
<td>Home Health Aide</td>
<td>Hour Agency: Yes</td>
<td>Agency: Business License</td>
<td></td>
</tr>
<tr>
<td>T1999HG-H</td>
<td>Household Related Goods and Services Hourly</td>
<td>Hourly Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
<td></td>
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<tr>
<td>T1999HG-I</td>
<td>Household Related Goods and Services Item/Invoice</td>
<td>Each Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
<td></td>
</tr>
<tr>
<td>T1999AI-I</td>
<td>Appliances for Independence Item/Invoice</td>
<td>Each Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
<td></td>
</tr>
<tr>
<td>T1999AF-I</td>
<td>Adaptive Furniture Item/Invoice</td>
<td>Each Agency: Yes IC: Yes</td>
<td>VIF is required (goods only)</td>
<td></td>
</tr>
</tbody>
</table>
Vendors (Independent Contractors and Agencies) that provide SERVICES *
IC = Independent Contractor

<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>
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</thead>
<tbody>
<tr>
<td>97124</td>
<td>Massage Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Group Practice or Individual Specialized Therapist</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Massage Therapist License</td>
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<tr>
<td>S8990</td>
<td>Naprapathy</td>
<td>Visit</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<td></td>
<td><strong>Allowed Providers:</strong> Group Practice or Individual Specialized Therapist</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Naprapathic Physician License</td>
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<tr>
<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><strong>Allowed Providers:</strong> Group Practice or Individual Specialized Therapist</td>
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<tr>
<td>S9470</td>
<td>Nutritional Counseling Adults</td>
<td>Hourly</td>
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<td>Agency: Business License</td>
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<td><strong>Allowed Providers:</strong> Group Practice or Individual</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Registered Dietician License</td>
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<tr>
<td>G0152</td>
<td>Occupational Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Individual Occupational Therapist</td>
<td></td>
<td>IC: Yes</td>
<td>IC: OT License</td>
</tr>
<tr>
<td></td>
<td>or Group Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G0151</td>
<td>Physical Therapy</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Group Practice or Individual Physical Therapist</td>
<td></td>
<td>IC: Yes</td>
<td>IC: PT License</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</td>
</tr>
<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Group Practice or Individual Specialized Therapist</td>
<td></td>
<td>IC: Yes</td>
<td>IC: License in a mental health profession whose scope of practice includes play therapy</td>
</tr>
<tr>
<td>T1003</td>
<td>Private Duty Nursing LPN</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Home Health Agency, Rural Health Clinic, FQHC or Individual</td>
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<td>IC: Yes</td>
<td>IC: LPN License</td>
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<tr>
<td>T1002</td>
<td>Private Duty Nursing RN</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Home Health Agency, Rural Health Clinic, FQHC or Individual</td>
<td></td>
<td>IC: Yes</td>
<td>IC: RN License</td>
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<tr>
<td>T1005HHA</td>
<td>Respite Home Health Aide</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
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<td></td>
<td><strong>Allowed Providers:</strong> Respite Agency</td>
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<td>IC: Yes</td>
<td></td>
</tr>
<tr>
<td>T1005SD</td>
<td>Respite Standard</td>
<td>Per 15 min</td>
<td>Agency: Yes</td>
<td>Agency: Business License</td>
</tr>
<tr>
<td></td>
<td><strong>Allowed Providers:</strong> Individual Provider (not RN, LPN or HHA) or Respite Provider Agency</td>
<td></td>
<td>IC: Yes</td>
<td>IC: Pre-Hire Packet</td>
</tr>
</tbody>
</table>
### Vendors (Independent Contractors and Agencies) that provide SERVICES *

<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>
</table>
| T1005LPN     | Respite LPN  
**Allowed Providers:** Respite Provider Agency or Individual LPN                      | Per 15 min     | Agency: Yes   | Agency: Business License                |
|              |                                                                                          |                | IC: Yes       | IC: LPN License                         |
| T1005RN      | Respite RN  
**Allowed Providers:** Respite Provider Agency or Individual RN                       | Per 15 min     | Agency: Yes   | Agency: Business License                |
|              |                                                                                          |                | IC: Yes       | IC: RN License                          |
| G0153        | Speech/Language Pathology  
**Allowed Providers:** Individual Speech Language Pathologist (SLP) or Group Practice | Per 15 min     | Agency: Yes   | Agency: Business License                |
|              |                                                                                          |                | IC: Yes       | IC: Business License                    |
| T1999TS      | Technology for Safety and Independence  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999CR      | Computer Purchase (item)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999PR      | Printer Purchase (item)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999FX      | Fax Machine Purchase (item)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999CPEP    | Cell Phone and Related Equipment Purchase (item)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999IS      | Internet Service  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999CELL    | Cell Phone Service  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999LS      | Landline Service  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999ICL     | Internet/Cell Phone/Landline Service (bundled)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999IC      | Internet/Cell Phone Service (bundled)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
| T1999IL      | Internet/Landline Service (bundled)  
**Allowed Providers:** Vendor                                                                 | Each           | Agency: Yes   | VIF is required (goods only)            |
|              |                                                                                          |                | IC: Yes       |                                        |
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 questions.
APPENDIX E: 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>
</thead>
<tbody>
<tr>
<td>Employment Supports (includes Job Coach)</td>
<td>T2019</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Homemaker/Direct Support</td>
<td>99509</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Respite – Standard</td>
<td>T1005SD</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Transportation Time</td>
<td>T2007</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Transportation Mile</td>
<td>T2049</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Pre-Hire Packet: Division of Health Improvement (DHI) form, copy of identification card (ID), and three fingerprint cards.

**Employee Packet: Employee Information Form, Employee Agreement, Transportation Appendix (if performing driving services), Declaration of Relationship, W-4 (Federal and State), I-9 Form, Direct Deposit Authorization Form (optional).

HELPFUL REMINDERS

- Employer of Record (EOR) documentation must be completed and approved before an employee’s enrollment can be approved and before an employee can begin work.
- Employees may not begin working until they have passed their initial COR Background Check (this is included in the Pre-Hire Packet).
- Employees cannot be paid until their entire Employee Packet has been successfully processed.
- In order to drive, an employee must have current vehicle registration and insurance in the employee’s name.
- Please remember that Employees must complete a new Employee Agreement for each Plan year. If Xerox does not receive an Employee Agreement before the beginning of the new Plan, the employee may not get paid on time.
Appendix F: Vendor Payment Request Form
Toolkit: Invoices

Use these tips for completing Invoices!

Q: What is this toolkit for?

A: This toolkit explains how to make the invoice process work smoothly! Participants, Employers and Contractors can work together to help make sure invoices get processed and paid on time.

Keys to Getting Paid the Correct Amount, On Time!

Follow these tips to avoid delayed payment of your invoice.

- **Be sure ALL vendor paperwork has been completed and submitted.**

- **Effective July 15, 2011, invoices that are received by Xerox more than 90 days after the service was provided, will not be processed for payment.**

According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the vendor performed the service. This means that all invoices must be submitted to Xerox no later than Midnight on the 90th day after services have taken place. **Any invoices that are submitted after this time limit will not be paid by Xerox and will be returned to you.** Also, if you need to make corrections to your invoice, you must complete them within this timeframe (90 days from the date the service was performed).

- **Follow the CURRENT Vendor Payment Schedule.**

  Keep a copy of the Vendor Payment Schedule in front of you. If you submit your invoice after the deadline on Saturday, your vendor payment may be delayed.

  **Note:** The **deadline** for submitting invoices is always on a Saturday by Midnight (before 12:00 am on Sunday).

- **Use your legally registered business name.**

  For example,

  - 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: ACS PO Box 27460, Albuquerque, NM 87125** 01/01/14

Provider Agency/Contractor ___Dr. John Doe________________ Is this a correction to a PRIOR invoice? □ Yes □ No

Date of Invoice (mm/dd/yyyy) ___04/29/2011_____________ Total Invoice $ _81.06______ (must match total $ below)

Participant Name: ___Pauline Participant_________________________ Participant Date of Birth: ___01/01/1975______________

<table>
<thead>
<tr>
<th>Date</th>
<th>Service Code</th>
<th>Hours per Day</th>
<th>Rate per Hour</th>
<th>Rate per Unit</th>
<th># of Units **</th>
<th>Total Charge</th>
<th>What Service(s) were provided? Be specific.</th>
<th>Participant present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/25/11</td>
<td>G0151</td>
<td>4</td>
<td>$13.51</td>
<td>$54.04</td>
<td></td>
<td>Physical therapy</td>
<td>X Y N</td>
<td></td>
</tr>
<tr>
<td>4/28/11</td>
<td>G0131</td>
<td>2</td>
<td>$13.51</td>
<td>$27.02</td>
<td></td>
<td>Physical therapy</td>
<td>X Y N</td>
<td></td>
</tr>
</tbody>
</table>

Total Hours | Total Units/Charge | 6 | $81.06

*Hours are entered for any service that is delivered hourly.

**A ‘UNIT’ is defined as a service that is delivered as a single item (each), per 15 minutes, daily, monthly, mile or visit/session.

Provider/Vendor Signature: ___Dr. John Doe_________________________ Date ___04/29/2011___

Example

<table>
<thead>
<tr>
<th>Date</th>
<th>SVC Code</th>
<th>His per Day</th>
<th>Rate per Hour</th>
<th>Rate per Unit</th>
<th>Units per Day</th>
<th>Total Charge</th>
<th>What Service(s) were provided? Be specific.</th>
<th>Participant present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>04-25-11</td>
<td>S9470</td>
<td>4</td>
<td>12.00</td>
<td>$48.00</td>
<td></td>
<td>Nutritional Counseling</td>
<td>X Y N</td>
<td></td>
</tr>
<tr>
<td>04-25-11</td>
<td>T2049</td>
<td>0.034</td>
<td>50</td>
<td>$17.00</td>
<td></td>
<td>Mileage to the community center and home</td>
<td>X Y N</td>
<td></td>
</tr>
<tr>
<td>04-27-11</td>
<td>T2033</td>
<td>25.00</td>
<td>1</td>
<td>$25.00</td>
<td></td>
<td>Customized In-Home Living Support</td>
<td>X Y N</td>
<td></td>
</tr>
<tr>
<td>Total Hours</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
<td>51</td>
<td>$90.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This form MUST be attached to the Payment Request Form (PRF) for all services.

*Signature date must be on or after the last service date.*
Self-Directed Community Benefit

Toolkit: Timesheets

Q: What is this toolkit for?

A: This toolkit explains how to make the timesheet process work smoothly! Participants, Employers and Employees can work together to help make sure timesheets get processed and paid on time.

TIPS FOR GETTING PAYCHECKS THAT ARE ACCURATE AND ON TIME!

• Be sure ALL employee paperwork has been completed & submitted.

• Effective January 1, 2014, timesheets that are received by Xerox more than 90 days after the service was provided will not be processed for payment. According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the employee worked. This means that all timesheets must be submitted to Xerox (via fax or the FOCoS online system) no later than Midnight on the 90th day after services have taken place. Any timesheets that are submitted after this time limit will not be paid by Xerox and will be returned to you. Also, if you need to make corrections to your timesheets, you must complete them within this timeframe (90 days from the date the employee worked).

• Follow the CURRENT payroll periods.

Keep a copy of the payroll schedule in front of you. Timesheets submitted after Saturday’s deadline may result in a delayed paycheck. If you would like a copy of the current Payroll Payment Schedule, please contact the Xerox Help Desk (1-866-916-0310).

Note: The deadline for submitting timesheets is always on a Saturday by Midnight (before 12:00 am on Sunday).

• Service dates on all timesheets need to be ON or BEFORE the last day of the timesheet period.

You cannot enter, submit or sign a timesheet for work not yet performed. For example, if the pay period ends on Friday, May 20th, you cannot enter time for services you will provide on Monday, May 23rd even if the services are generally similar or the same.

• Services Provided-field on the Timesheet.

Enter descriptions of tasks and services provided to the Participant.

• Timesheets need to be complete and correct (see example on Page 3 of this toolkit).
• **Both the Employee and the Employer need to sign and date the timesheet.**

• **Fax your timesheet.**
  Only fax your timesheet **one (1) time** unless you are faxing a corrected timesheet or if you have been asked to refax it. If it is a corrected timesheet, check the box **Yes** for “Is this a correction to a PRIOR Timesheet?” Not following these guidelines can cause delays in a check being issued. **The fax number is 866-302-6787.**

• **Use the exact same name on your timesheet as used for your employee paperwork.**
  For example, if you completed paperwork as William J Smith and you enter Billy Smith on your timesheet, we won’t know who you are. This will cause a delay in getting paid.
2-Week Self-Directed Timesheet for Payment

Have you faxed this timesheet before (is it a duplicate)? □ Yes □ No If Yes, when?

<table>
<thead>
<tr>
<th>Date</th>
<th>Time In</th>
<th>Time Out</th>
<th>Hours</th>
<th>Service Code</th>
<th>Services Provided (Please enter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/07/2011</td>
<td>AM 8:00</td>
<td>PM AM 11:00</td>
<td>3</td>
<td>99509</td>
<td>Prepared meals, shopped for groceries.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/08/2011</td>
<td>AM 8:00</td>
<td>PM 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></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/09/2011</td>
<td>AM 8:00</td>
<td>PM AM 11:00</td>
<td>3</td>
<td>99509</td>
<td>Helped Pauline pack for trip to visit brother.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/10/2011</td>
<td>AM 10:00</td>
<td>PM AM 12:00</td>
<td>2</td>
<td>99509</td>
<td>Cleaned apartment.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/11/2011</td>
<td>AM 12:00</td>
<td>PM AM 1:00</td>
<td>1</td>
<td>99509</td>
<td>Prepared meals for next week.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/14/2011</td>
<td>AM 10:00</td>
<td>PM AM 12:00</td>
<td>2</td>
<td>99509</td>
<td>Laundry, cleaned apartment.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/15/2011</td>
<td>AM 12:00</td>
<td>PM AM 3:00</td>
<td>3</td>
<td>99509</td>
<td>Teach Pauline how to use computer.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/16/2011</td>
<td>AM 2:00</td>
<td>PM AM 8:00</td>
<td>6</td>
<td>99509</td>
<td>Worked with Pauline on practicing better safety skills at home.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/17/2011</td>
<td>AM 8:00</td>
<td>PM 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></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>05/18/2011</td>
<td>AM 8:00</td>
<td>PM AM 1:00</td>
<td>5</td>
<td>99509</td>
<td>Prepared frozen meals for next week.</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td>PM AM</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Hours for Week 1 ➞ 18 Must not be over 40
Total Hours for Week 2 ➞ 24 Must not be over 40
Total Hours for Timesheet (2 weeks) ➞ 42 Must not be over 80

Midnight Rule
10PM-12AM (1st day)

Split Shift
8AM – 11AM Homemaker/Direct Support Services

Signed & dated on or after last service date

Ellie Employee

Employee Name: Ellie Employee
Employee ID# (last 4 digits of employee’s social security #: 1234

Participant: Pauline Participant

Participant’s Date of Birth: Begin Date 05/07/2011, End Date 05/20/2011

Ellie Employee

Employee Name: Ellie Employee
Employee ID# (last 4 digits of employee’s social security #: 1234

Pauline Participant

Participant’s Date of Birth: Begin Date 05/07/2011, End Date 05/20/2011

Pauline Participant

Employee Name: Pauline Participant
Employee ID# (last 4 digits of employee’s social security #: 1234

Signed & dated on or after last service date

Managed Care Policy Manual as of March 3, 2015
Appendix I: Employer of Record (EOR) Self-Assessment
APPENDIX J: LIST OF SDCB ACRONYMS AND SERVICES

### 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>
SELF-DIRECTED COMMUNITY BENEFITS

Behavior Support Consultation Services
Customized Community Supports
Employment Supports
Emergency Response
Environmental Modification
Home Health Aide
Homemaker
Nutritional Counseling
Private Duty Nursing
Related Goods
Respite
Skilled Therapy Services for Adults
Specialized Therapies
Transportation (non-medical)
P   NAMING CONVENTION FOR FOCosonline
NEW MEXICO MEDICAID PROGRAM COPAYMENTS (Revised version 8-6-2014, Effective 8-1-2014)

CHIP RECIPIENT COPAYMENTS

Categories of Eligibility 071, 0420, and 0421

Pharmacy Copayment:

§ 2. per drug item - Does not apply if the copayment for unnecessary brand name drug is assessed. See exemptions below, including exemptions for family planning, preventive services, and prenatal drug items.

Practitioner Services Copayments:

§ 5. Outpatient visits to physician or other practitioner, 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:

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 6, 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, 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
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 MCOs actual members. Health education materials include, but are not limited to: condition specific brochures, letters or phone calls, member newsletters, posters and member handbooks.

Incentives: Items that are used to encourage behavior changes in the MCOs enrolled members or health promotion incentives used to motivate members to adopt a healthy 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. service’s or any other objects that are designed or intended to be used in health education or outreach.

Incentives may not be used in conjunction with the distribution of alcohol or tobacco products.

Marketing: Any medium of communication that is written, audio/oral, personal face-to-face, or electronic, including any promotional activities, intended to increase the MCOs or subcontractors membership or to “Brand” a MCO or subcontractors name or organization.

Marketing Materials: General audience materials such as: general circulation of brochures, flyers, newspaper, phone book advertisements, websites and/or any other materials that are designed, intended, or used for increasing the MCOs or subcontractors membership or establishing a brand. Such marketing materials may include but are not limited to: scripts, provider directories, leaflets, posters or any material that is distributed or circulated by the MCO and subcontractors, including providers (e.g. personal care providers).
**Outreach**: Any means of educating or informing the MCOs enrolled members about health issues. See also “health education” and “retention”.

**Outreach Materials**: Materials that are designed, intended, or used for health educational or outreach purposes only to the MCOs enrolled members. See “Health Education Materials”.

**Event Promotion**: Any activity in which any approved marketing materials are given away or displayed where the intent is to provide health education and/or outreach.

**Event Promotional Materials**: See “marketing materials”.

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

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 Managed Care.

   Outreach is communication with enrolled members for the purpose of member retention, and improving the health status of enrolled members. Retention efforts must be directed to currently enrolled members who are determined to be at risk for attrition, or analysis of membership trends such as decreased utilization of preventative services.

   For marketing, outreach, retention activities and materials, the MCO must first submit for review and approval by HSD. In addition to the approval, the MCO must provide HSD with a copy of the approved material, advertising copy or publication in which the ad will be placed.

   1. **Materials**
      The use of any material, including those that pertain to incentives, marketing, outreach, and promotions must have prior approval from the HSD Marketing Committee. Materials that have been previously approved but will be included in a specific activity must also be included in the MCOs submission for review and approval by HSD.

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

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

The MCO shall submit an annual Marketing & Outreach Plan as well as a quarterly report which outlines the MCOs activities. The report shall include the following:

a. The HSD Marketing Committee and HSD MCO Contract Manager will review the MCOs annual Marketing & Outreach plan and quarterly report to determine if the MCOs participation in any events were in violation of this policy. If HSD determines the MCO was in violation of this policy, the MCO may be subject to sanctions. Failure by the MCO to disclose any event attended may also result in Administrative Action.

C. MCO Health Plan Name and Logos
MCO Health Plan Name and Logos can be included on event flyers or websites that are produced by hosting organizations without prior approval. MCO must monitor and police their health plan name and logo use to prevent misuse.

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

E. Restrictions
The following restrictions apply to all marketing, outreach and retention activities. The following shall not be allowed:

a. Incentive items such as t-shirts, buttons, balloons, key chains, etc. unless the intent of such a give-away is outreach in nature (i.e. for educating members about benefits of safety, immunizations, well-care, or as a “reward/incentive” for member accessing care as part of an approved incentive program). All incentive items must be prior approved by the HSD Marketing Committee.

b. Solicitation of any individual face-to-face, door-to-door or cold call telemarketing, including that of the MCOs subcontractors;

c. Any reference to competing plans;

d. Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;

e. Unsolicited direct mail advertising, including that of the MCOs subcontractors;

f. Marketing of non-covered services;

g. Reference to the word “free” for any covered service;

h. Use of HSD/MAD logo;

i. Inaccurate, misleading, confusing or negative information about HSD, or statements designed to recruit potential members, including that of the MCOs subcontractors;

j. Discriminatory marketing practices; 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 or forms on behalf of the potential enrollee. The prohibition
covers all situations, whether sponsored by the MCO, its parent company, or any other entity.

HSD reserves the right to impose additional restrictions at any time.

4. When materials are submitted for review, the MCO shall ensure that:
   a. All materials identify the MCO as an HSD/MAD managed care provider and are consistent with all the requirements for information to members described in the contract, regulations and managed care policies and procedures.
   b. All materials shall specify “Such services are funded in part with the State of New Mexico”.
   c. All materials shall include information that describes what the submission is, its purpose and what population (if applicable) it will target. This information may be submitted in form of a cover letter, MCO Contractor plan form, or in the body of an email.
   d. All materials two or more pages must be numbered.
   e. All materials must be 6th grade reading level or lower and each submission must provide the reading level with and without, proper names, medical terminology, etc.
   f. All materials must indicate if a translated version will be made available to the member and or how the member can request a translated version.
   g. All materials must be submitted timely and at least 30 calendar days prior to use allowing the HSD Marketing Committee at least 15 business days to review. If an “Expedited” review is needed, please submit and allow at least five (5) business days for review and approval or request special accommodations for unique circumstances.
   h. All materials used for any type of Medicaid or managed care training purposes must be submitted for review and approval before training occurs (i.e. handouts, power points, etc.). If MCO plans are collaborating and conducting one training using the same power point presentation, one MCO plan should be designated and submit the material on behalf of all MCOs (e.g. Annual Tribal Meetings).
   i. All materials that correspond with each other should be submitted to HSD for review together, in lieu of separate submissions.
   j. All approved materials shall be provided in a printed, hard copy to the HSD Marketing Liaison in the English and translated Spanish version (if applicable).
   k. Outreach material may not include the words: “free”, “join”, “enroll”, “sign up” or similar verbiage unless approved by the HSD Marketing Committee. If the MCO intends on using such language in any of the materials, the request for approval must include how the message is related to an Outreach goal.
   l. The MCO shall ensure that subcontractors are advised that they too must comply with this policy. All materials must be submitted by all subcontractors to the MCO for review and approval based on the MCO specific policies and procedures for marketing.

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

The MCO Contractor shall ensure that all subcontractors are advised that they must comply with this policy. Failure of a subcontracted provider to adhere to this policy may result in sanctions/penalties to the Contractor contracted with such a provider.
All subcontractors must only advertise the services in which they provide and must not make any reference to HSD/MAD Programs, Medicaid or services in which the MCO Contractor provides.

A. Temporary Sanctions/Penalties
Any activities or materials found in violation of this policy will be subject to sanction regardless of previous approval or terms in contractual agreements. The MCO Contractor will be placed on “Moratorium” status and will not be allowed to advertise via the following:
   a. Print advertising;
   b. Radio advertising;
   c. Billboards;
   d. Bus Wraps (including bus stops)

The MCO Contractor will monitor its subcontractors found in violation of this policy and impose any temporary sanctions for marketing or advertising of the subcontractors services and/or business.

The HSD Marketing Review Committee will review the “Moratorium” status on an annual basis, or at HSD’s discretion, to determine if the MCO Contractor or subcontractor is now deemed compliant.

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

Revision Dates: August 15, 2014

Effective Date: January 1, 2014

1. **Broad Standards**
   a. The Managed Care Organization (MCO) shall establish a patient centered initiative based on the National Committee for Quality (NCQA), Joint Commission on Accreditation of Healthcare Organizations (JHACO) or Accreditation Association for Ambulatory Health Care (AAAHC) Patient-Centered Medical Home (PCMH) recognition program.
   b. The MCO shall develop a patient-centered, “whole person” model of care that emphasizes primary medical care that is comprehensive, team-based, coordinated, accessible and focused on quality and safety.

2. **Eligible Providers**
   A. The MCO shall develop PCMH initiatives with Primary Care physicians (DO or MD), Nurse Practitioners or Physician Assistants as defined by MAD regulation.

3. **Patient Centered Medical Home (PCMH)**
   A. **PCMH Principles**
      a. Every Member has a Primary Care Provider (PCP)
      b. Care is provided by a physician-directed team that collectively cares for the Member; and
      c. Care is coordinated and/or integrated across all aspects of health.
   
   B. **PCMH Model**
      The MCO shall develop PCMH models that:
      a. Provide patient-centered care;
      b. Practice evidence-based medicine;
      c. Participate in continuous quality improvement;
      d. Engage patients to actively participate in decision-making and provide feedback related to their care;
      e. Use Health Information Technology (HIT) and promote data exchange through a Health Information Exchange (HIE) to support care delivery; and
      f. Provide enhanced access to care including but not limited to extended office hours outside of 8:00 AM to 5:00 PM (Mountain Time), open scheduling, and alternative modes of communication including web-based or telephonic options.
   
   C. **PCMH Standards**
      a. Access to care (i.e. same day appointments, extended hours, group and e-visits, and patient portals). Appointments based on condition and the provider can accommodate same day scheduling as needed.
         i. In-person access
         ii. After-hours access
         iii. Telephone and electronic access
      b. Accountability
         i. Performance and clinical quality improvement
      c. Comprehensive whole person care
         i. Preventive services
         ii. Medical services
iii. Mental health, substance abuse, and developmental services
iv. Comprehensive health assessment and intervention scope of Services
d. Continuity
   i. Personal clinician assigned
   ii. Personal clinician continuity
   iii. Organization of clinical information
   iv. Clinical information exchange
   v. Specialized care setting
e. Coordination and Integration
   i. Population data management
   ii. Electronic health record
   iii. Care coordination
   iv. Test & result tracking
   v. Referral & specialty care coordination
   vi. Comprehensive care planning
   vii. End of life planning
f. Person and family centered care
   i. Language / cultural interpretation
   ii. Education & self-management support
   iii. Experience of care
D. PCMH Participation Requirements:
   a. In order to participate, practitioners must:
   b. Meet the six PCMH standards outlined above
   c. Adopt and implement evidence-based diagnosis and treatment guidelines
   d. Fully implement an electronic medical record system and participate in the NM Health Information Exchange (HIE)
   e. Identify and partner with the MCO to manage high need patients; implement a system for care coordination
   f. Measure and report PCMH quality measures as defined by the HSD/MAD which may include HEDIS or patient satisfaction data
   g. Have a continuous quality improvement plan that references medical home standards

4. School Based Health Center Medical Homes
The MCO shall develop a medical home model of care for School Based Health Centers (SBHC) that emphasizes primary medical care that is continuous, comprehensive, coordinated, accessible, compassionate and culturally appropriate for youth. The SBHC medical home model core elements include:
A. Enhance access and continuity that includes:
   a. Access during office hours; includes same day scheduling and telephone access
   b. After-hours access; after hours clinical advice via phone/electronic access to providers
   c. Continuity/Coordination; each student assigned a personal physician and practice is responsible for coordinating care
   d. Students receive information about the role of the medical home; coordinating care, getting advice after hours, responsibility to share information about care received in other places and self management
   e. Meet cultural, linguistic and health needs of the population served
2. Identify and manage patient population that includes:
   a. Collect and use data for population management; identify students in need of preventive or chronic care services, those have not recently been seen by a practitioner or those with specific medications
   b. Patient Information and clinical data collected and entered into an Electronic Health Record (EHR); demographics, health insurance, and vital stats (height, weight, BMI, plotted on a growth chart)
   c. Comprehensive health assessment completed for each student; immunization assessment, family/social/cultural issues, depression screening, tobacco use, behaviors affecting health and medical history

3. Plan and manage care that includes:
   a. Care management; providing a written plan of care to student/family
   b. Identify high risk students
   c. Implement evidence based guidelines
   d. Medication management and E-prescribing

4. Provide self-care support and community resources that includes:
   a. Support self-care process; develop self management plan and provide educational resources
   b. Provide referrals to community resources; maintain a list of key community resources

5. Track and coordinate care that includes:
   a. Referral tracking and follow-up
   b. Test tracking and follow up; flag abnormal tests
   c. Manage transitions; including to adult care

6. Measure and improve care that includes:
   a. Measure performance to improve clinical quality; for at least three (3) preventive or chronic conditions
   b. Measure student experience at the SBHC
   c. Implement Continuous Quality Improvement

5. PCMH Monitoring
   A. The MCO shall use a standardized set of measurements including: utilization, cost and quality measures to monitor:
      a. Preventive care
      b. Chronic disease management
      c. Acute care
      d. Over utilization
      e. Safety
   B. The MCO shall measure patient satisfaction using surveys and other predefined sources of information annually.

6. PCMH Payment Methodology
   A. An enhanced payment methodology for PCMHs must be standardized between all contracted MCOs
   B. Methodology may include:
      a. Ongoing fee-for-service payments
      b. Tiered per member per month (PMPM) payment based on PCMH recognition level including a base level if practice is not NCQA, JHACO, or AAAHC recognized.
      c. Enhanced payment to practices that meet quality targets (pay for performance)
d. Shared savings model

7. **Health Homes**
   A. 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.
   B. 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.
   C. **Health Home Core Services**
      a. Comprehensive Care Management; must include:
         i. Assessment of preliminary risk conditions and health needs;
         ii. Care Management Plan development, which will include client goals, preferences and optimal clinical outcome and identify specific additional health screenings required based on the individual’s risk assessment;
         iii. Assignment of health team roles and responsibilities;
         iv. Development of treatment guidelines for health teams to follow across risk levels or health conditions;
         v. Oversight of the implementation of the Care Management Plan which bridges treatment and wellness support across behavioral health and primary care;
         vi. Through claims-based data sets and patient registries, monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and
         vii. Development and dissemination of reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs.
      b. Care Coordination; the implementation of the individualized, culturally appropriate comprehensive care management plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports.
         i. Developed in active partnership with the member and the member’s family, as appropriate
         ii. Promotes integration and cooperation among service providers and reinforces treatment strategies that support the member’s motivation to better understand and actively self-manage his or her health condition
         iii. Specific activities include, but are not limited to, appointment scheduling, conducting referrals and follow-up monitoring, participating in hospital discharge processes and communicating with other providers and client/family members
      c. Comprehensive Transitional Care; coordinating plans of care, reducing hospital admissions, easing the transition to long term services and supports and interrupting patterns of frequent hospital emergency department use.
         i. Care providers collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on enhancing clients’ and family members’ ability to manage care and live safely in the community, and enhancing the use of proactive health promotion and self management.
      d. Health Promotion; services must include:
         i. Provide health education specific to an individual’s chronic conditions;
ii. Development of self-management plans with the individual;
iii. Education regarding the importance of immunizations and screening for overall general health;
iv. Providing support for improving social networks;
v. Providing health-promoting lifestyle interventions, including but not limited to: substance use prevention and/or reduction; smoking prevention and cessation; nutritional counseling, obesity reduction and prevention and increasing physical activity; and
vi. Reinforce strategies that support the member’s motivation to better understand and actively self-manage her or his chronic health condition.

e. Individual and Family Support; services must include, but are not limited to:
   i. Navigating the health care system to access needed services;
   ii. Assisting with obtaining and adhering to medications and other prescribed treatments;
   iii. Identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in their community; and
   iv. Arranging for transportation to medically necessary services.

f. Referral to Community and Social Support Services; services include:
   i. Identifying available community-based resources
   ii. Actively manage appropriate referrals and access to care, engagement with other community and social supports, and follow-up post-engagement
   iii. Common linkages could include continuation of healthcare benefits, eligibility, disability benefits, housing, legal services, educational supports, employment supports, and other personal needs consistent with recovery goals and the treatment plan.

8. Health Home Payment Methodology
   A. An enhanced payment methodology for Health Homes must be standardized between all contracted MCOs
   B. Per member per month (PMPM) payment will be based on HSD/MAD staffing model requirements
   C. 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:
Appendix K: ABP Benefit Chart
Appendix L: Alternative Benefit Plan-Exempt Medically Frail Conditions List
Appendix M: Chronic Substance Dependency Checklist
Appendix N: SMI Checklist
Appendix O: NF LOC Supplement
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:**
   I. 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.

i. 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

ii. 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.

iii. 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.

iv. 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.</td>
<td>Covered under EPSDT if medically necessary (perhaps unlikely) without the life time limit.</td>
</tr>
<tr>
<td></td>
<td>Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.</td>
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</tr>
<tr>
<td>Cardiac Rehab</td>
<td>Limited to 36 hours per cardiac event</td>
<td>Covered under EPSDT if medically necessary without the limit on hours.</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Not covered</td>
<td>Covered under EPSDT if medically necessary (this very rarely happens)</td>
</tr>
<tr>
<td>Drug items that do not require a prescription (OTC)</td>
<td>Not covered</td>
<td>Covered using the same provisions as for recipient under EPSDT in the standard Medicaid program.</td>
</tr>
<tr>
<td></td>
<td>- except for items that are related to prenatal care; low dose aspirin for preventing cardiac events; treatment of diabetes, items used for contraception (foams, devices, etc.)</td>
<td>Note that 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</td>
</tr>
<tr>
<td></td>
<td>Note that coverage of diabetic test strips, and similar items are described under medical supplies, below.</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Glasses and contact lens</td>
<td>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>
</tr>
<tr>
<td>Hearing aids</td>
<td>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>
</tr>
<tr>
<td>Home health services</td>
<td>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>
</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</td>
<td>Not covered.</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.</td>
</tr>
<tr>
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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.</td>
<td>Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.</td>
</tr>
<tr>
<td>Pulmonary rehab</td>
<td>Limited to 36 hours per year</td>
<td>Covered under EPSDT without the limitation on the number of visits.</td>
</tr>
<tr>
<td>Rehabilitation and Habilitation</td>
<td>Rehabilitative services for short-term physical, occupational, and speech therapies are covered.</td>
<td>Covered under EPSDT without the limitation on duration.</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 Recipients under age 19 are not enrolled in ABPEC</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| therapy  
Speech and language pathology | Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment.  
Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, dependent on the approval of the MCO’S medical director, only if such services can be expected to result in continued significant improvement of the member’s physical condition within the extension period.  
Other than the above one-time extension, therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered. | |
| Extended care hospitals (long term care hospitals) | Extended care hospitals are not covered. Sometimes these are referred to as long term care hospitals (certified as acute care hospitals but focus on care for more than 25 days)  
NF long term care stays are not covered by ABP except as a temporary step down level of care following discharge from a | Covered under EPSDT without the limitations. |
### SERVICE LIMITATIONS FOR ABP RECIPIENTS (COE 100) FOR AGES 21 AND ABOVE

| SERVICE          | 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
| Sleep studies    | hospital prior to being discharged to home. Refer to page 4 for more information.
|                  | Covered under EPSDT
| Transplants      | Limited to 2 per lifetime
|                  | Covered under EPSDT without the dollar amount limitation.

### 3. ABP BENEFITS THAT MAY EXCEED THE STANDARD MEDICAID COVERAGE

The following services must be provided to ABP recipients, even though these services MAY NOT BE covered for standard Medicaid eligible recipients, but may already be required to be provided through an MCO to a member.

<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 of or in addition to the preventative care exam. See extended comments on the preventive services, item 4, at the end of this document.</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>MAD benefits for the Autism Spectrum diagnosis is being extended up through age 20 as an EPSDT benefit. However, in order to be comparable to commercial plans, the ABP plan also includes ages 21 and 22 for this benefit.</td>
</tr>
</tbody>
</table>
Disease management

Electroconvulsive therapy (ECT)

Educational materials and counseling for a healthy lifestyle

Nutritional counseling

| Skilled nursing | 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. |

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 aged 19 and 20, all of the screening and preventive services available to this age group under the EPSDT provisions are benefits for both ABP recipients and ABP Exempt recipients.

The requirements related to ABP include assuring the ABP population’s preventive care benefits include the recommendations of the United States Preventive Services Task Force (USPSTF). These recommendations are found at the following website:

http://www.uspreventiveservicestaskforce.org/recommendations.htm

ABP covered preventive services is not intended to be to only those services on the list. Other preventive services that are generally found in a commercial insurance plan would be covered. Also, the list is not intended to describe or replace the preventive screening and services available to EPSDT recipients.

Therefore, the following list includes items that may need special attention or comment, but we have removed items from the list that routinely performed in hospitals at the time of birth (PKU screening for example), and services for children for which the EPSDT screenings and service components are
already more comprehensive. When the website above is updated, with new recommendations, those additions and charges are considered to be part of the requirement.

<table>
<thead>
<tr>
<th>Service</th>
<th>USPSTF Recommendations</th>
<th>Application to Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm 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. The counseling component does not have to include any providers not current covered by the Medicaid program.</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</td>
<td>Covered – already in MC coverage</td>
</tr>
</tbody>
</table>

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Managed Care Policy Manual  as of March 3, 2015
<table>
<thead>
<tr>
<th>Service</th>
<th>USPSTF Recommendations</th>
<th>Application to Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteriuria screening: pregnant women</td>
<td>The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks’ gestation or at the first prenatal visit, if later.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Blood pressure screening in adults</td>
<td>The USPSTF recommends screening for high blood pressure in adults age 18 years and older.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>BRCA screening, counseling about</td>
<td>The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Breast cancer preventive medication</td>
<td>The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Breast cancer screening</td>
<td>The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
</tbody>
</table>
| Breastfeeding                               | The USPSTF recommends interventions during At this time, based | Managed Care Policy Manual  as of March 3, 2015
<table>
<thead>
<tr>
<th>Service</th>
<th>USPSTF Recommendations</th>
<th>Application to Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>counseling</td>
<td>pregnancy and after birth to promote and support breastfeeding.</td>
<td>on comparison with commercial plans MAD interprets this as instruction or counseling that would occur during the routine prenatal care and postpartum care; and possibly assessed for any issues or lack of success by the pediatrician treating the newborn.</td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Chlamydial infection 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>
</tr>
<tr>
<td>Chlamydial infection screening: pregnant women</td>
<td>The USPSTF recommends screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men 35 and older</td>
<td>The USPSTF strongly recommends screening men age 35 years and older for lipid disorders.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: men</td>
<td>The USPSTF recommends screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>younger than 35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women</td>
<td>The USPSTF strongly recommends screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>ages 45 and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol abnormalities screening: women</td>
<td>The USPSTF recommends screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>younger than 45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Depression screening: adults</td>
<td>The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>Covered – already in MC coverage requirements. The “depression care supports” component does not have to include any provider types not currently covered by the Medicaid program.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Service</th>
<th>USPSTF Recommendations</th>
<th>Application to Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes screening</td>
<td>The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Falls prevention in older adults: exercise or physical therapy</td>
<td>The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>At this time, based on comparison with commercial plans MAD interprets this as detection of the issue during routine annual preventive care exams, and referring as necessary. The referrals might be to community programs, home use of TV and DVD programs, etc. We do not believe the requirement is to pay for the exercise class or physical therapy.</td>
</tr>
<tr>
<td>Falls prevention in older adults: vitamin D</td>
<td>The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Folic acid supplementation</td>
<td>The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Gonorrhea screening: women</td>
<td>The USPSTF recommends that clinicians screen all sexually active women, including</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Healthy diet counseling</td>
<td>The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.</td>
<td>Coverage of this benefit exceeds the coverage currently found in Medicaid rules. It may include covering additional providers when there is a referral. May be performed by a physician, dietician, or other qualifying practitioner.</td>
</tr>
<tr>
<td>Hepatitis B screening: pregnant women</td>
<td>The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.</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>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 risk should be screened for HIV.</td>
<td>Technically a new requirement, but good practitioners would already be performing this function.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HIV screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.</td>
</tr>
<tr>
<td>Intimate partner violence screening: women of childbearing age</td>
<td>The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.</td>
<td>Technically a new, requirement, but good practitioners would already be performing this function during exams.</td>
</tr>
<tr>
<td>Obesity screening and counseling: adults</td>
<td>The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.</td>
<td>Covered – already in MC coverage requirements. May be performed by a physician, dietician, or other qualifying practitioner.</td>
</tr>
<tr>
<td>Osteoporosis screening: women</td>
<td>The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Rh incompatibility screening: first pregnancy visit</td>
<td>The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient.</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
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<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rh incompatibility screening: 24–28 weeks' gestation</td>
<td>The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Sexually transmitted infections counseling</td>
<td>The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) in all sexually active adolescents and for adults at increased risk for STIs.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient state plan service.</td>
</tr>
<tr>
<td>Skin cancer behavioral counseling</td>
<td>The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.</td>
<td>Broader requirement than currently exists as a standard Medicaid recipient service.</td>
</tr>
<tr>
<td>Tobacco use 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</td>
</tr>
<tr>
<td>Service</td>
<td>USPSTF Recommendations</td>
<td>Application to Medicaid</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Syphilis screening: pregnant women</td>
<td>The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.</td>
<td>Covered – already in MC coverage requirements or as a standard Medicaid recipient service.</td>
</tr>
</tbody>
</table>
Appendix L: Alternative Benefit Plan-Exempt Medically Frail Conditions List

**Alternative Benefit Plan-Exempt Medically Frail Conditions List**

Effective January 1, 2014

Revised August 15, 2014

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>
</tr>
</thead>
<tbody>
<tr>
<td>Acquired Immune Deficiency Syndrome (AIDS)</td>
</tr>
<tr>
<td>ALS (Lou Gehrig’s Disease)</td>
</tr>
<tr>
<td>Angina Pectoris</td>
</tr>
<tr>
<td>Arteriosclerosis Obliterans</td>
</tr>
<tr>
<td>Artificial Heart Valve</td>
</tr>
<tr>
<td>Ascites</td>
</tr>
<tr>
<td>Blindness</td>
</tr>
<tr>
<td>Cancer (current diagnosis/treatment, within five years)</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>Chronic Substance Use Disorder – <em>refer to the Chronic Substance Dependency (CSD) Criteria Checklist effective July 1, 2010 (or subsequent replacement version)</em></td>
</tr>
<tr>
<td>Cirrhosis of the Liver</td>
</tr>
<tr>
<td>Compromised Immune System</td>
</tr>
<tr>
<td>Coronary Insufficiency</td>
</tr>
<tr>
<td>Coronary Occlusion</td>
</tr>
<tr>
<td>Crohn’s Disease</td>
</tr>
<tr>
<td>Condition</td>
</tr>
<tr>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Dermatomayositis</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td>Friedreich’s Disease</td>
</tr>
<tr>
<td>Hemophilia</td>
</tr>
<tr>
<td>Hepatitis C (Active)</td>
</tr>
<tr>
<td>HIV+</td>
</tr>
<tr>
<td>Hodgkin’s Disease</td>
</tr>
<tr>
<td>Huntington’s Chorea</td>
</tr>
<tr>
<td>Hydrocephalus</td>
</tr>
<tr>
<td>Intermittent Claudication</td>
</tr>
<tr>
<td>Juvenile Diabetes</td>
</tr>
<tr>
<td>Kidney Failure</td>
</tr>
<tr>
<td>Lead Poisoning with Cerebral Involvement</td>
</tr>
<tr>
<td>Leukemia</td>
</tr>
<tr>
<td>Lupus Erythematosus Disseminate</td>
</tr>
<tr>
<td>Malignant Tumor (If treated/occurred within previous five years)</td>
</tr>
<tr>
<td>Metastatic Cancer</td>
</tr>
<tr>
<td>Motor or Sensory Aphasia</td>
</tr>
<tr>
<td>Multiple or Disseminated Sclerosis</td>
</tr>
<tr>
<td>Muscular Atrophy or Dystrophy</td>
</tr>
<tr>
<td>Myasthenia Gravis</td>
</tr>
<tr>
<td>Myotonia</td>
</tr>
</tbody>
</table>
Open Heart Surgery
Organ Transplant
Paraplegia or Quadriplegia
Parkinson’s Disease
Peripheral Arteriosclerosis (If treated within previous three years)
Polyarteritis (Periarteritis Nodosa)
Polycystic Kidney
Posterolateral Sclerosis
Renal Failure
Serious Mental Illness – refer to the Serious Mental Illness (SMI) Criteria Checklist effective July 27, 2010 (or subsequent replacement version)
Sickle Cell Anemia
Silicosis
Splenic Anemia (True Banti’s Syndrome)
Still’s Disease
Stroke (CVA)
Syringomyelia
Tabes Dorsalis (Locomotor Ataxia)
Terminal illness requiring hospice care
Thalessemia (Cooley’s or Mediterranean Anemia)
Topectomy and Lobotomy
Wilson’s Disease
Appendix M: Chronic Substance Dependency Checklist
Appendix N: SMI Checklist
SCHOOL-BASED HEALTH CENTERS

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

A. SBHC Program Overview

School-Based Health Centers (SBHCs) are a vital part of the healthcare delivery system in New Mexico. They are comprehensive primary health care centers on school grounds that provide physical and behavioral health services to students. Working with the NM Department of Health, Office of School and Adolescent Health (DOH/OSAH) and the Managed Care Organizations (MCOs) who help insure Medicaid-eligible students and families, the HSD/MAD/SHO strives to offer “the right care, at the right time, in the right setting” – in this case at schools where students spend much of their time.

In 2012-2013, the 56 school campuses with SBHCs supported by Human Services Department, Medical Assistance Division School Health Office (HSD/MAD/SHO) and DOH/OSAH served 14,500 students and were accessible to 33,000 students in various regions and demographics throughout New Mexico. Of those served, 40% do not have (or do not know of) another place to receive healthcare.

SBHCs have been found to be especially effective in offering developmentally and culturally appropriate primary care, preventative services, and behavioral health services for students in rural areas where other health care options are limited. Areas of particular focus and strength of services offered by SBHCs include:

1. Health screenings - Early and Periodic Screening, Diagnosis, Treatment (EPSDT)
2. Asthma screening and management
3. Obesity and Diabetes type-2 screening and management
4. Depression and anxiety screening and treatment
5. STI and reproductive health services
6. Care coordination

SBHCs promote positive health behaviors and healthcare literacy by increasing healthy knowledge and decision-making skills in the students they serve. And by serving students in a school setting, SBHCs limit the amount of time students miss school to receive healthcare services, leading to increased in-class time and fewer absences for a positive effect on student academics as well as positive health outcomes.

SBHCs are uniquely positioned to be on the ground members of the care coordination team and should be centrally involved in reaching and working with student members: SBHCs can assist the MCO with reaching the student member to conduct the initial risk level assignment. SBHCs use a comprehensive risk and resiliency-screening instrument called the Student Health Questionnaire (SHQ). The SHQ identifies a student’s current health needs, presence of mental health issues and/or substance abuse, and living arrangements. Through the SHQ, SBHCs often identify higher risk students, i.e., those who are medically complex or fragile, have high emergency room use, have a high risk mental health diagnosis or are seriously and persistently mentally ill, and homeless; SBHCs
can be utilized after the initial risk assignment to complete a more comprehensive assessment of the student member who appears to have a higher level need for care coordination; SBHCs, based on the assessment, can then participate with students, families and the MCOs in development and implementation of the students’ care plans.

The HSD/MAD/SHO supports School-Based Health Centers by providing Medicaid claims reimbursements through MCOs, ensuring that SBHCs and their medical providers get paid for their services to Medicaid clients as appropriate. Working with DOH/OSAH, HSD/MAD/SHO helps certify SBHCs to ensure they meet state quality standards. HSD/MAD/SHO also promotes quality improvement of SBHCs so they can offer the best services possible.

B. SBHC Certification Site Review Process
   I. FQHC/Medical Entity Sponsored Sites

   1. MCO Responsibilities
      The MCOs will be responsible for doing the certification visits for SBHC sites that are sponsored by a FQHC or other medical entity (i.e., hospital). The MCOs will visit and certify the sponsoring entity and sponsoring entities will then be responsible for making sure that the sites adhere to the Standards and Benchmarks for Participation as required by DOH/OSAH. The MCOs will communicate the results of these visits with DOH/HSD.

   2. DOH/HSD Responsibilities
      DOH/OSAH will communicate with the MCOs which SBHC sites are under the sponsorship of a FQHC or other medical entity. DOH/OSAH will do visits to individual SBHC sites to ensure that the Standards and Benchmarks for Participation are being appropriately adhered to. If DOH/OSAH finds serious deficiencies that they feel may affect Medicaid billing, they will place the site on a Corrective Action Plan (CAP) and request that HSD/MAD/SHO participate in a return visit to ensure the CAP has been properly implemented. HSD/MAD/SHO will retain the ability to suspend Medicaid billing privileges for any sites that does not adhere to the Standards and Benchmarks for Participation.

   I. Independent/Non-Medical Entity Sponsored Sites

      DOH/OSAH and HSD/MAD/SHO will maintain the current process of a joint certification site review process for “independent” sites that are sponsored by non-medical entities (i.e., non-profits, universities, Regional Education Cooperatives (RECs)) to ensure that the Standards and Benchmarks for Participation are being appropriately adhered to. This site review will also serve as the certification to the MCOs that the site is allowed to participate in Medicaid billing. Sites found to be in non-compliance the Standards and Benchmarks for Participation will be placed on a Corrective Action Plan that will be monitored by DOH/OSAH and HSD/MAD/SHO. All deficiencies will need to be corrected before a site is certified/re-certified for participation in Medicaid billing. The results of the site reviews will be communicated with the MCOs.
C. Confidential Services and Suppression of Explanation of Benefits (EOBs) for SBHC Services

Under New Mexico law, there are a number of circumstances in which an adolescent (an un-emancipated minor) may consent to receive services without parental consent, including the following:

1. Treatment for Sexually Transmitted Diseases:
   Under Section 24-1-9 (capacity to consent to examination and treatment for a sexually transmitted disease), any person regardless of age has the capacity to consent to an examination and treatment by a licensed physician for any sexually transmitted disease; however, under Section 24-1-9.4, disclosure of the test results is authorized “to the subject of the test or the subject’s legally authorized representative, guardian or legal custodian.”

2. Pregnancy Examination and Diagnosis:
   Under Section 24-1-13 (pregnancy; capacity to consent to examination and diagnosis), any person, regardless of age, has the capacity to consent to an examination by a licensed physician for pregnancy.

3. Family Planning Services:
   Under Section 24-8-5 (prohibition against imposition of standards and requirements as prerequisites for receipt of requested family planning services) there are no prerequisites for parental consent to obtain family planning services.

4. Behavioral Health Services:
   Under Section 32A-6-14 (treatment and habilitation of children; liability), parental consent is not required to receive “individual psychotherapy, group psychotherapy, guidance, counseling or other forms of verbal therapy that do not include any aversive stimuli or substantial deprivations.”

D. MCO Responsibilities

1. The New Mexico Human Services Department’s (HSD’s) contracts with the MCOs require that the MCOs adopt and implement written confidentiality policies and procedures that conform to state and federal laws and regulations.
2. The MCOs are contractually required to preserve adolescent members’ confidentiality rights. The MCOs are required to honor adolescent members’ rights to receive confidential services to the same extent that they are required to ensure adult members’ privacy rights under HIPAA and other state and federal confidentiality provisions.
3. The MCOs are contractually required by HSD to identify third-party coverage and coordinate benefits with applicable third parties. However, for purposes of the SBHC/MCO project, this requirement has been waived by HSD since it applies to seeking coverage of confidential services first from private third-party payors. SBHCs should not bill private payors for services rendered to an adolescent who, according to state law, consented to receive them without parental knowledge.
4. The MCOs are to suspend the distribution of Explanation of Benefits (EOBs) for all services provided at SBHCs.
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.
A. 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:

- Timeliness in all phases of the process;
- Maintain member confidentiality and protect PHI information;
- Emphasize maintenance of complete and organized files;
- Emphasize importance of documentation; and
- 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:

- 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.
- 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.
- 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:

- 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.
General Requirements
The MCOs are required to comply with all reporting requirements established by HSD as specified in the State’s Medicaid Managed Care Agreement (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 reports is incorporated in this Manual as Appendix Q: MCO Reports.

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 also 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 and state staff input. Beginning the day HSD issues finalized Report Instructions and Templates, MCOs will have thirty (30) calendar days to implement existing report content changes.

MCO Reporting
The HSD’s report management process involves:
- tracking MCO submissions via Xerox secure FTP site (File Transfer Protocol);
- downloading submissions;
- acknowledging receipt of reports within forty-five (45) calendar days of report due date;
- performing the initial review by HSD Intake staff for timeliness and completeness;
- assigning reports to subject matter experts for review and analysis;
- compiling and filing reports and analyses;
- monitoring review timeframes to ensure HSD staff completes timely reviews; and
- uploading State feedback (Acceptance, Rejection or Review Tool) to the Xerox FTP site.

Report Rejection
Reports can be rejected at any point during the State’s review process. Reasons for rejection include reports that are incomplete or missing data, improperly formatted, submitted on obsolete templates, lack of attestation and reports determined to contain inaccurate information.
The Intake staff uploads the rejection form and indicates the reason for the rejection. Resubmissions are due within ten (10) business days of the date of rejection.

**Report Resubmission**
MCOs upload resubmissions within the deadline specified on the rejection form. It is important that the MCOs accurately label each subsequent submission with the appropriate version number (Ex: v2, v3, v4).

**Technical Assistance**
Contract Management staff and Financial Management Bureau staff are available to provide technical assistance to MCOs regarding the reporting process in the following areas:
- State’s review and feedback
- Extension of submission deadlines
- Resolution of reporting concerns

**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](mailto: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](mailto: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](mailto: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.
For any email notification pertaining to the above direction, MCOs must use the HSD developed template included in this section as Appendix R: Systems Availability Incident or Event Report.
### Appendix Q: 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 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 used 60% or more of their annual community benefit budget and (iv) identify members whose cost of care in the community is greater than 60% of the cost of care in a private nursing facility.</td>
<td></td>
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<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.</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>
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<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>8</td>
<td>Level of Care (LOC) Report</td>
<td>Monthly</td>
<td>To monitor members meeting nursing facility level of care determinations, timeframes and care settings.</td>
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<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
<td>Comment</td>
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<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 60% of the cost of care in a private nursing facility.</td>
<td></td>
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<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 the number of unreachable members and efforts to contact them.</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Provider Satisfaction Survey Report</td>
<td>Annually</td>
<td>To understand how the provider satisfaction survey is administered and to monitor and review the results from the survey, including information on long-term care, behavioral health and physical health providers.</td>
<td>REVISED – LOD #29B</td>
</tr>
<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>REVISED – LOD #29B</td>
</tr>
<tr>
<td>16</td>
<td>Encounter Processing and Submission Report</td>
<td>Monthly</td>
<td>To track encounter submission to HSD for paid managed care organization (MCO) claims. This includes an aggregate total encounters submitted and accepted by HSD to date, new outstanding encounters to be submitted, encounters requiring adjustments to be submitted, void encounters to be submitted, and encounters that have been denied by HSD’s MMIS system and require correction and resubmission.</td>
<td>LOD 29A: Frequency of report submission changed from Quarterly to Monthly</td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
<td>Comment</td>
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<tr>
<td>17</td>
<td>Member Care Coordination Activities Report</td>
<td>Quarterly</td>
<td></td>
<td>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>18</td>
<td>UM Program Description</td>
<td>Annually</td>
<td>To monitor the MCO's UM Program and the activities for implementing the tasks (work plan) and evaluation.</td>
<td>REVISED – LOD #29B</td>
</tr>
<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>Combined with Report 18</td>
</tr>
<tr>
<td>20</td>
<td>Disease Management Description</td>
<td>Annually</td>
<td>To monitor and review the MCO's Disease Management program description and evaluation.</td>
<td>REVISED – LOD #29B</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>Combined with Report 20</td>
</tr>
<tr>
<td>22</td>
<td>QM/QI Program Description and associated work plan</td>
<td>Annually</td>
<td>To monitor the MCO's QM/QI Program Evaluation for the previous year's activities.</td>
<td>REVISED – LOD #29B</td>
</tr>
<tr>
<td>23</td>
<td>QM/QI Program Annual Evaluation</td>
<td>Annually</td>
<td>To evaluate the MCO's QM/QI Program Description and associated work plan.</td>
<td>REVISED – LOD #29B</td>
</tr>
<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 CAHPS results report.</td>
<td>REVISED – LOD #29B</td>
</tr>
<tr>
<td>26*</td>
<td>Payment Reform Pilot Project Updates</td>
<td>Monthly</td>
<td>To monitor any updates of approved payment reform pilot projects that are on-going through the MCO. The report will also include information pertaining to provider compliance with best practices and patient outcomes.</td>
<td>On Hold – 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>27</td>
<td>Activities of the Member Advisory Board</td>
<td>Semi-Annually</td>
<td>To monitor the activities of the Member Advisory Board, including a summary of the MCO’s approach to inviting members (representing all eligibility groups and populations), the meeting agenda, minutes, attendees and scheduling of the next meeting.</td>
<td>LOD #29: Report 27 Combined with Reports 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></td>
<td>LOD #29: Combined with Reports 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 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>DISCONTINUED – LOD #29</td>
</tr>
<tr>
<td>29</td>
<td>Business Continuity and Disaster Recovery (BC-DR) 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>30</td>
<td>Health Education Plan</td>
<td>Annually</td>
<td>To describe the MCO’s plans to provide health education and promote health literacy.</td>
<td>REVISED – LOD #29B</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>Combined with Report 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 Reports 27 and 27a.</td>
</tr>
<tr>
<td>Report No.</td>
<td>Report Title</td>
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<td>Report Objective</td>
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<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></td>
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<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 provide qualitative analysis of critical incidents and MCO’s actions in response to critical incidents for the reporting period.</td>
<td>LOD #29: Report Number changed from 36B to 36.</td>
</tr>
<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>
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<tr>
<td>38</td>
<td>Provider Training and Outreach Plan</td>
<td>Annually</td>
<td>To monitor the MCO’s plans for provider training and outreach and review the annual evaluation.</td>
<td>REVISED – LOD #29B</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>Combined with Report 38</td>
</tr>
<tr>
<td>40</td>
<td>Over-and-Under Utilization of Services</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>
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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>41</td>
<td>Utilization Management Report</td>
<td>Quarterly</td>
<td>To monitor unduplicated member utilization and the total amount paid for behavioral health services, physical health and long-term care services. The report captures member utilization by date of service for paid claims.</td>
<td></td>
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<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></td>
</tr>
<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 (OTC), generic, and brand drugs.</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>CSA Report</td>
<td>Quarterly</td>
<td>To monitor the number and types of members served through core service agencies (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></td>
</tr>
<tr>
<td>47</td>
<td>Claims Activity Report - Monthly</td>
<td>Monthly</td>
<td>To capture data regarding the disposition of claims, timeliness of claims adjudication, payments on clean claims to providers, interest paid, and claim aging. This report captures claims data separately for behavioral health providers, physical health providers, Indian Health Service, Tribal health providers, Urban Indian providers (I/T/Us), and specialty-pay providers (day activity providers, assisted living providers, nursing facilities, home care agencies, and community benefit providers). The billing provider listed on the</td>
<td></td>
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<tr>
<td>Report No.</td>
<td>Report Title</td>
<td>Frequency</td>
<td>Report Objective</td>
<td>Comment</td>
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<tr>
<td>48</td>
<td>Patient Centered Medical Homes Report</td>
<td>Semi-Annually</td>
<td>To track (i) the number of PCMH established; (ii) the number of members that were referred to and joined a PCMH; (iii) outcomes, including emergency room (ER) utilization and hospital admission and readmission; and (iv) PCMH NCQA recognition and other accreditation.</td>
<td>LOD #29: Frequency of submission changed from Quarterly to Semi-Annually</td>
</tr>
<tr>
<td>49</td>
<td>Provider Network Development and Management Plan</td>
<td>Annually</td>
<td>To monitor the MCO's provider network development and management plan to ensure that all medically necessary covered services are accessible and available.</td>
<td>REVISED – LOD #29B</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>Combined with Report 49</td>
</tr>
<tr>
<td>51</td>
<td>Provider Suspensions and Terminations</td>
<td>Semi-Annually</td>
<td>To capture information on the disposition of claims and the timeliness of payments to providers on clean claims.</td>
<td>LOD 29: Frequency of report submission changed from Quarterly to Monthly</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 assignments/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>
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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>55</td>
<td>Geographic Access Report</td>
<td>Quarterly</td>
<td>To monitor members' access to services by county and across urban, rural, and frontier counties.</td>
<td></td>
</tr>
<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>LOD #29A: Report 56 is no longer on hold.</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 (SBHCs).</td>
<td></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>LOD #29: Frequency of submission changed from Quarterly to Semi-Annually</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 the MCO’s performance in processing requests for and delivering new adaptive equipment and modifications or repairs to adaptive equipment.</td>
<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>On Hold – LOD #29</td>
</tr>
<tr>
<td>66*</td>
<td>Health Homes Report</td>
<td>Quarterly</td>
<td>The details of this report are still pending.</td>
<td>On Hold – LOD #29</td>
</tr>
</tbody>
</table>
Appendix R: Systems Availability Incident or Event Report

<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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