

# THE DISABILITY COALITION

*A Coalition of Persons with Disabilities, Family Members, and Advocates*

P.O. Box 8251, Santa Fe, New Mexico 87504-8251  
Telephone: (505) 983-9637

September 28, 2018

Brent Earnest, Secretary  
New Mexico Human Services Department  
PO Box 2348  
Santa Fe, NM 87504-2348

Submitted by email to : [madrules@state.nm.us](mailto:madrules@state.nm.us)

Re: HSR vol. 41, #23  
8.308.6 NMAC – MCO Enrollment  
8.308.12 NMAC – Community Benefit

Secretary Earnest:

The Disability Coalition offers the following comments on the Human Services Department's proposed revisions to the above-referenced Medicaid regulations.

## 8.308.6 – Managed care organization enrollment

8.308.6.10(B)(2) – Currently, individuals who are eligible for Medicaid and meet level of care requirements for long-term services and supports are eligible to receive the full array of Community Benefit services. Those who are not otherwise eligible may qualify to receive those services through allocation to a waiver slot (formerly known as the Disabled & Elderly 1915(c) waiver and then the CoLTS "c" waiver). The department proposes to delete the language authorizing that eligibility and replace it with language stating that those receiving Community Benefit services must be enrolled with a managed care organization, an entirely unrelated thought.

We agree that the regulation on MCO enrollment is a somewhat odd place to put the provision on access to Community Benefits through a waiver allocation for individuals whose incomes do not otherwise qualify them for Medicaid. However, it is not clear that this is covered elsewhere in the HSD regulations. It should not be withdrawn here without ensuring that it is retained in other portions of the regulations.

### 8.308.12 – Community benefit

#### 1) 8.308.12.18

a) Paragraphs H, K and N – HSD proposes to impose caps on a number of services in the self-directed community benefit (SDCB), including non-medical transportation (paragraph H), related goods (paragraph K), and specialized therapies (paragraph N), for individuals enrolling in the SDCB on or after January 1, 2019. We appreciate the department’s decision to grandfather those already enrolled in the SDCB so that they will not be subject to an arbitrary loss of services. However, we reiterate our objections to the proposed random and unjustified caps for new enrollees.

HSD has not explained how the amounts were determined or why these levels were deemed to be appropriate. Moreover, it is not clear why any cap is being imposed at all. All SDCB services must fit within an approved annual budget and service plan, so there appears to be no justification for arbitrary limits on particular services within the package. The limits also are contrary to the very concept of self-direction, in which the individual is supposed to have control over his or her services and should be able to make tradeoffs, within the allotted budget amount, to meet individual needs and preferences.

The caps also may violate the Americans with Disabilities Act by discriminating against enrollees based on the type or severity of their disability – for example, by reducing access to therapies for individuals whose disabilities require higher amounts of these services. Additionally, across-the-board caps that don’t recognize individual circumstances are inappropriate. As an example, a single statewide cap on transportation that ignores the different needs of a person living in an urban area as compared to someone living in a rural or frontier area discriminates against those who live in more remote parts of the state, such as the Navajo Reservation and is arbitrary and unacceptable.

b) Paragraph O – We support this proposed addition, providing an allowance for start-up goods to support individuals transitioning to self-direction.

2) 8.308.12.19(A) – The current language of the regulation recites that Medicaid is the payor of last resort and that services covered by third parties will not be covered by Medicaid. The proposed change would add a provision that the managed care organization may verify that a good or service is not covered by a third party payor source by requesting a denial letter. No specifics are given as to how or when such a request may be made, timeframes for requesting or receiving such a letter, or whether the good or service must be provided to (and covered for) an enrollee while this verification proceeds.

We do not object to allowing the MCOs to verify coverage in cases of possible third-party responsibility. However, we urge the department to clarify this provision to ensure that enrollees have prompt access to services while the verification process is pending to ensure that individual recipients are not penalized for tardy responses or failures to respond on the part of third-party payors.

3) Electronic visit verification (EVV), 8.308.12.7(I), 8.308.12.18(G)(4), and 8.308.12.22 – Several provisions relating to EVV are added here or moved from elsewhere in the department's regulations. EVV is a system for electronic verification of service provision through a telephone-based or on-line check-in system to document time and location. The proposed regulations, 8.308.12.18(G)(4), would condition payment for personal care services (PCS) on use of EVV.

The intent of EVV is to prevent fraud and abuse by documenting that services are actually being provided. However, EVV is riddled with problems, which HSD appears to ignore in proposing that payment will be made only where EVV used.

Some of the problems are technological. EVV systems are not yet sufficiently reliable to be used as the predicate for payment. The problems are exacerbated in a rural state like New Mexico where internet or even telephone service may be unavailable in many areas. Numerous reports indicate that the computer tablets issued for caregiver use are unreliable and often cannot be used to report. When reporting often is technologically impossible, it should not be used as the basis to decide whether services will be paid for.

EVV also raises serious concerns about infringement on the rights of individuals receiving services. Requiring reporting from specific locations limits the freedom of persons with disabilities who use PCS to move freely out of their homes and to engage in community activities. Systems that track the movements of recipients and caregivers are an intolerable invasion of privacy. Moreover, requiring that the caregiver check in from a pre-determined location at a certain time may waste scarce PCS hours when time must be spent returning to that location in order to be there at the stated time.

That EVV is not yet ready for prime time was demonstrated by the U.S. Congress when it amended the federal 21<sup>st</sup> Century Cures Act in July of this year to delay for one year, from January 2019 to January 2020, the Act's provisions mandating adoption of EVV to avoid a diminution of the federal Medicaid funding match. We urge HSD to take advantage of this delay to ensure that any verification system for PCS is reliable, workable, and is applied in a way that does not infringe on the rights of persons with disabilities who rely on PCS. Any regulatory provision conditioning payment on use of EVV should be delayed until that occurs.

We note that EVV was developed in New Mexico without the stakeholder consultation set out in the Cures Act. The department consulted with some (but not all) PCS provider agencies, but did not involve consumers or direct care workers in that process. A requirement conditioning service payment on EVV use should not proceed until meaningful consultation with those essential parties has taken place.

Thank you for your consideration of these comments.

Sincerely,

*Ellen Pinnes*

Ellen Pinnes  
for The Disability Coalition