



Medical Assistance Division

Managed Care Policy Manual

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Contents

- 1. General Provisions..... 1
- 1.1. General Information 1
- 2. Provider Network 3
- 2.1. Service Termination and Provider Closure 3
- 2.2. MCO-Initiated Provider Network Closures and Reductions 5
- 2.3. Provider Monitoring..... 6
- 2.4. Requirements for Provider Enrollment 7
- 2.5. Institutional Type Providers..... 11
- 2.6. Providers Whose Services are Based on Orders and Referrals 13
- 2.7. Rendering Providers 15
- 2.8. Using the Web to Verify Attending, Ordering, Referring, Rendering or Prescribing
Providers 19
- 2.9. Exclusions 22
- 2.10. General Information on the Requirements based on Procedure Codes 24
- 2.11. Appendices..... 30
- 2.11.1. Notification of Change in Services – Notification of Transition..... 31
- 2.11.2. Transition Plans Narrative..... 33
- 2.11.3. Transition Plan A 34
- 2.11.4. Transition Plan B 37
- 3. Member Education..... 39
- 3.1. Policies and Procedures 39
- 3.2. Member Handbook..... 41
- 3.3. Provider Directories 44

3.4.	Member Identification Card.....	45
3.5.	Member Advisory Board	46
4.	Care Coordination.....	47
4.1.	General Information	47
4.2.	Care Coordination Functions	48
4.3.	Health Risk Assessment	52
4.4.	Comprehensive Needs Assessment	55
4.5.	Community Benefit Service Questionnaire.....	60
4.6.	CNA Reassessments.....	62
4.7.	Comprehensive Care Plan Requirements	63
4.8.	Staffing Requirements and Delegations	69
4.9.	Engagement of Members.....	72
4.10.	MCO Care Coordination with 1915(c) HCBS Waivers: DDs, MF, and MI VIA.....	74
4.11.	Overview of Medicaid 1915(c) HCBS Waiver Program	75
4.12.	MCO Care Coordination Activities and the 1915(c) HCBS Waiver Service Plan (ISP or SSP)	78
4.13.	MCO Care Coordination Activities for MF EPSDT (Non-Waiver) Members Case Managed by UNM/MFCMP	80
4.14.	Transitions from the Non-Medicaid Brain Injury Services Fund to a Centennial Care MCO	81
4.15.	Appendix.....	83
4.15.1.	Health Risk Assessment	83
5.	Transitions of Care.....	85
5.1.	General Information	85
5.2.	Transitions of Care.....	87

5.3.	Transitions of Care Requirements.....	89
5.4.	Transition of Care Requirements for Pregnant Women.....	91
5.5.	Transfer from the Health Insurance Exchange.....	92
5.6.	Transitions of Care for Members Moving from a Higher LOC to a Lower LOC	93
5.7.	Transitions of Members Turning 21 Years of Age	94
5.8.	Transition for Members changing MCOs while Hospitalized.....	95
5.9.	Transition for Members Changing MCOs during Major Organ and Tissue Transplantation Services	97
5.10.	Transition for Members Changing MCOs while receiving Outpatient Treatment for Significant Medical Conditions	98
5.11.	MCO Requirements for Members Transitioning between MCOs.....	99
6.	Nursing Facilities	100
6.1.	General Information	100
6.2.	NF Procedures for Requests for Prior Approval	101
6.3.	Pre-Admission Screening and Resident Review (PASRR).....	102
6.4.	Level of Care Packet for Nursing Facilities.....	106
6.5.	Denial of Requests for Prior Approval	109
6.6.	Reserve Bed Days.....	110
6.7.	Initial Determination, Redetermination, and Pending Medicaid Eligibility.....	111
6.8.	Care Plan and Emergency Preparedness.....	112
6.9.	Retroactive Medicaid Eligibility.....	114
6.10.	Re-Admission Reviews	115
6.11.	Current/Retrospective Reviews.....	116
6.12.	Transfer from Another NF	117
6.13.	Changes in the LOC	118

6.14.	Discharge Status	119
6.15.	Reconsideration, Appeal, Administrative Hearing	120
6.16.	Communication Forms.....	121
6.17.	External Audits of NF LOC Determinations	122
6.18.	MCO Internal Audits of NF LOC Determinations	123
6.19.	Appendices.....	124
6.19.1.	NF LOC Communication Form	125
6.19.2.	NF LOC Notification Form	127
7.	Community Benefits.....	129
7.1.	General Information	129
7.2.	Definitions.....	130
7.3.	Nursing Facility Level of Care	132
7.4.	Continuous NF LOC for Certain Eligible Members	133
7.5.	External Audits of NF LOC Determinations	135
7.6.	MCO Internal Audits of NF LOC Determinations	136
7.7.	Registration for the CB for NOME Members	137
7.8.	Allocation Process	140
7.9.	Eligibility.....	142
7.10.	Closing/Inactivating an Allocation.....	144
7.11.	Registrant Notice Requirements	145
7.12.	Undeliverable Notice.....	146
8.	Agency-Based Community Benefits.....	147
8.1.	General Information	147
8.2.	Definitions.....	148

8.3.	ABCB Services Requirements	150
8.4.	ABCB Covered Services	151
8.5.	Adult Day Health Services	152
8.6.	Assisted Living	156
8.7.	Behavior Support Consultation	163
8.8.	Community Transition Services.....	169
8.9.	Emergency Response Services	172
8.10.	Employment Supports.....	174
8.11.	Environmental Modifications	180
8.12.	Home Health Aide.....	183
8.13.	Nutritional Counseling.....	186
8.14.	Personal Care Services	187
8.15.	Private Duty Nursing for Adults	222
8.16.	Nursing Respite Services.....	229
8.17.	Respite Services.....	232
8.18.	Skilled Maintenance Therapies	238
8.19.	Occupational Therapy for Adults.....	239
8.20.	Physical Therapy for Adults	244
8.21.	Speech Therapy for Adults.....	250
9.	Self-Directed Community Benefits	258
9.1.	Purpose	258
9.2.	Guiding Principles.....	259
9.3.	Philosophy of Self Direction	260
9.4.	Definitions.....	261

9.5.	SDCB Member Rights.....	264
9.6.	SDCB Member Responsibilities	265
9.7.	SDCB Supports	269
9.8.	Planning and Budgeting for SDCB Covered Services	282
9.9.	SDCB Qualifications for all SDCB Employees, Independent Providers, Provider Agencies and Vendors.....	285
9.10.	SDCB Covered Services.....	288
9.11.	Self-Directed Non-Covered Services	329
9.12.	SDCB Budget and Care Plan Approval Process	330
9.13.	Initial SDCB Budget Determination Process	331
9.14.	Initial SDCB Care Plan Approval Process.....	332
9.15.	Annual SDCB Budget Determination and Approval Process	334
9.16.	Annual SDCB Care Plan Development and Approval Process.....	335
9.17.	SDCB Budget and Care Plan Approval Process for Individuals Who Transitioned from the MI VIA Waiver Program	336
9.18.	Denials, Revisions and Reconsiderations of the SDCB Care Plan.....	338
9.19.	SDCB Care Plan Review Criteria.....	340
9.20.	Implementation of the SDCB Care Plan	342
9.21.	Transitions, Terminations, and Reinstatement Processes.....	348
9.22.	Appendices.....	351
9.22.1.	SDCB Range of Rates Chart	352
9.22.2.	SDCB Vendor Credentialing Requirements	355
9.22.3	Employee Credentialing Requirements Grid.....	362
9.22.4.	Vendor Toolkit: Invoices.....	364
9.22.5.	Employee Toolkit: Timesheets	367

10.	RESERVED	370
11.	Marketing.....	371
11.1.	General Information	371
12.	Patient-Centered Initiatives	378
12.1.	Broad Standards.....	378
13.	ABP Medically Frail and ABP Exempt.....	381
13.1.	General Information	381
13.2.	Determination of Medically Frail Diagnosis	382
13.3.	ABP Exempt Approval	383
13.4.	Appendices.....	384
13.4.1.	ABP Benefit Chart.....	385
13.4.2.	Alternative Benefit Plan-Exempt Medically Frail Conditions List.....	401
13.4.3.	Chronic SUD Criteria Checklist	405
13.4.4.	SMI Criteria Checklist	406
13.4.5.	SMI-SED Criteria	408
14.	School-Based Health Centers.....	414
14.1.	General Information	414
14.2.	Certification Process.....	416
14.3.	Recertification Process	419
15.	Indian Health Services, Tribal Health Providers, and Urban Indian Providers (I/T/U) 422	
15.1.	FQHC/Tribal 638 Claims Processing (Alamo and Pine Hill)	422
16.	Fair Hearings	423
16.1.	Administrative Hearings	423

16.2.	The Member’s HSD Administrative Hearing	425
16.3.	Appendices	436
16.3.1.	MCO Checklist – Acknowledgement of Receipt of a Member-Filed Grievance.....	437
16.3.2.	MCO Checklist for Member Grievance Final Letter	439
16.3.3.	MCO Checklist for Notice of Action Letter to Member	440
16.3.4.	MCO Checklist for Notice of Action Letter to Member Regarding VAS	444
16.3.5.	MCO Checklist for the Acknowledgements of Member Appeals.....	445
16.3.6.	MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision	449
16.3.7.	MCO Checklist for the MCO Member Appeal Final Decision Letter.....	450
17.	Managed Care Reporting	453
17.1.	General Information	453
17.2.	General Requirements	454
17.3.	MCO Reporting and Intake	455
17.4.	Report Rejection	456
17.5.	MCO Report Resubmission	457
17.6.	Report Revisions	458
17.7.	System Availability Reporting.....	459
17.8.	Appendices	460
17.8.1.	Centennial Care MCO Reports	461
17.8.2.	Systems Availability Incident or Event Report	467
18.	Quality	468
18.1.	Performance Improvement Projects (PIPs)	468
18.2.	Provider Satisfaction Survey	469
18.3.	Critical Incident Reporting	470

18.4.	Appendix.....	471
18.4.1.	Centennial Care Reporting Survey Template	472
19.	Program Integrity	476
19.1.	General Information	476
19.2.	Fraud, Waste and Abuse Requirements	477
19.3.	Suspension of Medicaid Payments for Credible Allegations of Fraud.....	482
19.4.	Adverse Action Reporting	483
19.5.	Recipient Explanation of Medical Benefits	485
19.6.	Fraud, Waste and Abuse Compliance Plan.....	486
20.	Pharmacy	487
20.1.	General Information	487
21.	Manual Acronyms	502

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 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 1: General Provisions</p>	<p>Revision dates: August 15, 2014; March 3, 2015</p> <p>Effective dates: January 1, 2014</p>
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1. General Provisions

1.1. 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 Medicaid Managed Care Services Agreement (the Agreement) and New Mexico Administrative Code (NMAC) rules pertaining to managed care.

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.

If there is a conflict between the Manual and the Agreement or NMAC rules, the 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 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.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 1: General Provisions	Revision dates: August 15, 2014; March 3, 2015 Effective dates: January 1, 2014
--	--------------------------------------	---

If you have any questions about the application of any policy, you should contact the Medical Assistance Division at 505-827-3100.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2. Provider Network

2.1. Service Termination and Provider Closure

Anticipated changes in the MCO provider network shall be reported to the MAD and Behavioral Health Services Division (BHSD) Contract Managers in writing within 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 calendar days of the MCO's knowledge about the change.

Anticipated Changes	
Notification	30 Calendar Days
Narrative	10 Calendar Days from date of Notification
Transition Plan A (Overall)	15 Calendar Days from date of Notification (if change is significant)
Transition Plan B (Member-Specific)	15 Calendar Days from date of Notification (if change is significant)
Unanticipated Changes	
Notification	5 Calendar Days
Narrative	10 Calendar Days from date of Notification
Transition Plan A (Overall)	15 Calendar Days from date of Notification (if change is significant)
Transition Plan B (Member-Specific)	15 Calendar Days from date of Notification (if change is significant)

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

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

the need for members to transition from one service provider to another, or when an MCO learns through means other than provider notification to the MCO. Notification is also expected if 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 10 calendar days of 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 10 calendar days from the date of notification of change or closure to the Contract Manager. In the Narrative, the MCO must explain all factors considered in making a determination that the change will not significantly impact the system and provide assurances that all members will be transitioned to new providers (if applicable). If the MCO determines the change or closure will significantly impact the delivery system, the MCO is required to submit Transition Plan A (Overall) and Transition Plan B (Client-Specific) to the Contract Manager within 15 calendar days of the official Notification and Narrative to HSD. In the event 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 members 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.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2.2. MCO-Initiated Provider Network Closures and Reductions

The MCOs will submit a written request to HSD regarding a significant change in the MCO's provider network to include either closure or reduction of providers. A significant change is defined as:

- Affecting more than 100 members statewide;
- Affecting more than 100 members in urban area;
- Affecting more than 50 members in rural area;
- Affecting more than 25 members in frontier area; and/or
- Limits or removes members' choice of providers, (e.g., closure of BH network, in rural and frontier areas).

The request must be submitted at least 60 calendar days prior to the MCO's intended action.

- The request must include a completed Notification form and provide justification for the closure or reduction of the specific provider network.
- The MCO must submit a current Geographical Access (Geo/Access) report demonstrating member access and include the accessibility overview, map, and analysis of the provider network.
- HSD will review and provide the MCO with a written approval or denial within 10 business days.
- At HSD's discretion, the MCOs may be required to submit all transition plan documents.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	--

2.3. Provider Monitoring

HSD/MAD monitors provider access and network adequacy in a variety of ways and through various reports. The following methods are utilized to monitor MCO provider access and network adequacy:

- Provider Satisfaction Survey;
- Member Satisfaction Survey;
- Secret Shopper Survey;
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) results;
- External Quality Review Organization (EQRO) Reviews;
- MCO Call Center Reports;
- Member Grievances & Appeals Report;
- Primary Care Physician/ Primary Care Provider (PCP) Report;
- Geo/Access Report;
- Network Adequacy Report; and
- Ad Hoc Reports.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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2.4. Requirements for Provider Enrollment

In considering provider enrollment, it is important for the MCO to understand there are many instances when claims cannot be paid, if the billing provider, rendering, referring, ordering, or attending physician or other practitioner is not enrolled and active with a status of 60 or 70. All managed care network providers, including network providers of an MCO subcontractor, must be enrolled through a Provider Participation Agreement (PPA) with the State Medicaid Agency. MAD may require that some “non-network” providers enroll based on the number of services rendered to New Mexico Medicaid recipients or other criteria.

Each MCO must submit a monthly listing of its network providers including the network providers of its subcontractors. This list is due by the tenth day of each month, reflecting the network providers for the previous month, and must include the following:

- Provider Name;
- Provider National Provider Identifier (NPI);
- Provider Taxpayer Identification Number (Social Security Number [SSN] or Federal Employer Identification Number);
- Provider Location Address; and
- If provider receives direct reimbursement from MCO or is employed by a provider receiving the payment.

The Patient Protection and Affordable Care Act (PPACA) Title 42, Part 455 of the Code of Federal Regulations requires attending, ordering, referring, rendering, and prescribing providers to be enrolled in the Medicaid program in order to meet PPACA program integrity requirements designed to ensure all attended, prescribed, ordered, referred, or rendered services, items, and admissions for Medicaid beneficiaries originate from properly-licensed providers who have not been excluded from Medicare or Medicaid. A provider who is enrolled through a PPA with MAD only as a fee-for-service (FFS) provider, only as a managed care provider, or who is enrolled as both FFS and managed care is considered to be “enrolled with Medicaid” for these purposes.

Therefore, the expectation is that most services and items will only be paid by the Medicaid program if the individual provider who attends, prescribes, orders, refers, or renders a service or

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

item is identified on the claim and is enrolled in the Medicaid program. Otherwise, the claim will be denied in accordance with Federal requirements.

This requirement now applies to both the Medicaid FFS program and to the Medicaid MCOs. Even with the implementation of these requirements, FFS and the MCOs will still be required to continue implementing more changes in the near future, such as:

- Including prescribing providers on pharmacy claims.
- Ensuring we are meeting Centers for Medicare & Medicaid Services (CMS) expectations for Indian Health Services (IHS) and Federally Qualified Health Centers (FQHCs), which may have changed since the previous CMS review.
- Working towards including rendering providers on more BH services and home- and community-based services (HCBS) developmentally disabled (DD) waiver services. (We may also begin enrolling opticians, hearing aid testers, and other individuals who provide services within a health care business entity. We are expanding our type and specialty listings to accommodate this action.

Under these requirements, it is possible that some practitioners will need to enroll in the Medicaid program; otherwise, the recipient may have to change individual providers in order for their services to be ordered, referred, prescribed, or attended by a Medicaid enrolled provider.

There are also some providers who are members of groups, agencies, and other facilities who have not enrolled individually as a member of the group, agency, or facility. To a lesser extent, there may be some individual providers who have not enrolled in the Medicaid program because they do not bill Medicaid, but who, never-the-less, order or prescribe services for the recipient that will be billed to Medicaid by other providers as a result of the order or prescription.

- MAD has developed, and made available on the Conduent New Mexico Medicaid Web Portal at <https://nmmedicaid.portal.conduent.com/webportal/providerSearch> a look-up tool to help providers obtain the NPI of a rendering, prescribing, ordering, referring, or attending provider. The instructions for using this web portal tool and contact information for the Conduent Provider Relations staff, are included in this document.



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Providers should use this tool to determine if any services they are providing to Medicaid recipients are based on prescriptions, orders, or referrals from a provider who is not enrolled in the Medicaid or managed care program.

Providers should also use this tool to determine if any provider or practitioner on their staff needs to be enrolled and to immediately begin the enrollment process if necessary.

- MAD allows provider enrollment as a Medicaid provider solely for the purpose of establishing appropriate enrollment for the services they order, refer, or prescribe without having to commit to seeing all Medicaid patients or even any Medicaid patients.


While discriminatory practices towards recipients are not allowed by State and Federal rules, a provider can still choose to limit his or her practice and participation in the Medicaid program in ways that are not discriminatory. Such limitations could include treating emergency situations only, only seeing recipients who are dually eligible for Medicare, limiting the number of patients or recipients seen, or to only see existing recipients without taking new patients.

This information may be useful to a provider who is hesitant to enroll in the Medicaid program.

Hospital, Residential, Nursing Facility (NF), HH, and Hospice Claims

The essential requirements are:

- The attending provider must be reported on the Universal Billing (UB) format claim for the following:
 - Inpatient hospital claims;
 - Hospice claims; and
 - Home health agency (HHA) claims (referring or ordering provider in the attending field).
- NF and intermediate care facilities for individuals with intellectual disabilities (ICF-IID) claims (referring or ordering provider in attending field);
- Residential facility claims (accredited residential treatment center [ARTC], RTC, and Group Homes) (referring or ordering provider in the attending field);

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 2: Provider Network</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- The rendering provider must be reported at the claim header level or on all lines on an outpatient hospital claim;
- A referring or ordering provider must be reported on an outpatient hospital claim when the service is the result of a referral; and/or
- If any of these providers submit claims on the CMS 1500 format, such as the physician component that corresponds to an inpatient or outpatient hospital claim, the requirements for rendering provider on the CMS 1500 format must be followed.

Referring or Ordering Providers on Claims


The essential requirements are:

- When the service provided is the result of a referral from another practitioner, that provider should be reported as the Referring or Ordering provider.
- In most instances, the MCO will not know if the service was based on a referral or not; therefore, in most instances, a referral cannot be required. Instead the provider must be relied upon to follow the instructions. However, there are certain types of providers whose services are performed only upon an order or referral from another provider such as independent laboratories, radiology facilities, suppliers of medical equipment, medical supplies, and oxygen. So it is possible to make the Referring or Ordering provider mandatory under these circumstances as indicated in this document.

Rendering Providers on Claims

The essential requirements are:

- The rendering provider must be identified for most services.
- Exceptions and special circumstances are described in this document.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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2.5. Institutional Type Providers

Specific Provider Reporting Requirements

- **HHA Claims; NF Claims:** the ordering provider’s NPI must be indicated in the attending provider NPI field.
- **Hospice Claims, Residential Provider claims** (ARTC, RTC, and Group Homes): the attending provider’s NPI is required.
- **Hospital Inpatient Claims** (including specialty hospitals): the attending provider’s NPI is required. See below for requirements for outpatient hospital claims.
- **Hospital Outpatient claims** (Including specialty hospitals): the rendering provider’s NPI must be reported on hospital outpatient claims. It may either be reported at the header level (if a single provider is the rendering provider) or at the line level (if there are different rendering providers for each service or line). Or they may always choose to report at the line level.

In many hospitals, the rendering provider may be a resident, an intern, or a supervised nurse, technician, or other individual who cannot enroll as a provider in their own right. In these situations, the provider overseeing the services for the recipient may be considered the rendering provider and reported as such.

Even though one may think of a lab code or radiology code, or some other service codes on the claim as not being performed by the provider, but rather by a lab or radiology technician, the provider overseeing the service for the recipient is still to be reported as the rendering provider on that line.

Correct Placement of Information on Claims

Attending Physicians for Inpatient Hospitals, Hospice Providers, Ordering Physicians or HHAs NFs, ICF-IID, and Residential Facilities

Paper UB format claim: Report the names and NPI in form locator 76 (Attending Provider Name and Identifiers)

Electronic 837 I claim: Report the names and NPI in loop 2310A

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	---

Data Element NM 101	Attending Provider = "71"
Data Element NM 103	Attending Provider Last Name
Data Element NM 104	Attending Provider First Name
Data Element NM 108	Identification Code Qualifier "XX"
Data Element NM 109	Attending Physician Primary Identifier NPI

Referring or Ordering Physicians (or other Providers), Reported when Applicable

Paper UB format: Report the NPI and name of the referring or other provider in Field Locator 78 (Other Physician's Name and Identifier)

The following loop, segment, and element places are used to report the referring provider's NPI and name, depending on whether reporting is being done at the header or line level

Referring Provider – 2310F (Header)/2420D (Line), Data Element NM101 = "DN"

Referring Provider Last Name – 2310F (Header)/2420D (Line), Data Element NM103

Referring Provider First Name – 2310F (Header)/2420D (Line), NM104

Referring Provider's NPI – 2310F (Header)/2420D (Line), NM108 = "XX"

Referring Provider's NPI – 2310F (Header)/2420D (Line), NM109

Referring or ordering providers are to be reported on claims when the service or item is the result of a referral or an order.

Rendering providers must be reported on claims for professional services such as reading or interpreting the results of an anatomical laboratory service or radiological images. Rendering providers may either be reported at the header level (if a single provider is the rendering provider) or at the line level.

The rendering, referring, or ordering provider may be a resident, intern, supervised nurse, technician, or other individual not typically enrolled as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider, referring, or ordering provider, as appropriate, and reported as such.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2.6. Providers Whose Services are Based on Orders and Referrals

Specific Provider Reporting Requirements

For the Medicaid program, MAD does not distinguish between an ordering and referring provider; information may be placed in either the ordering or referring provider fields.

The following providers should always have an ordering or referring provider for their services or items:

- Clinical diagnostic laboratories including clinical labs, diagnostic labs for physical tests and measurements, clinical labs with radiology, and other diagnostic laboratories.
- Hearing aid dealers, IV infusion services, opticians and other eyeglass dispensers, and medical supply and durable medical equipment (DME) companies.
- Occupational therapists, orthotists, physical therapists, prosthetists, speech and language pathologists, and rehabilitation centers.
- Radiology and radiation treatment facilities.

MAD recognizes that some therapists can self-refer; that is, upon seeing and evaluating a recipient, they may refer the recipient to themselves for treatment. When this occurs, the therapist must report himself or herself as the referring provider, as well as the rendering provider.

Sometimes the referring, ordering, or prescribing provider may be a resident, intern, or supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider and reported as such.

When a laboratory, radiology, or diagnostic test is for or includes a professional component for reading or interpretation of the results, the rendering provider must be provided in addition to the referring or ordering provider.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 2: Provider Network</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Correct Placement of Information

Referring or Ordering Physicians (or other Provider), Reported when Applicable

Paper CMS 1500 format: Report the NPI of the referring or ordering provider in Field Locator 17b (Other Physician’s Name and Identifier)

Electronic 837P: The following loop, segment, and element places are used to report the referring provider’s NPI and name, depending on whether reporting is being done at the header or line level

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = “DN”

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider’s NPI – 2310A (Header)/2420F (Line), NM108 = “XX”

Referring Provider’s NPI – 2310A (Header)/2420F (Line), NM109

Rendering Physician or Other Provider - Report on all Professional Services

Paper CMS 1500: Report the NPI of the rendering provider in Field Locator 24 J lower line Rendering Provider ID number

Electronic 837P: The following loop, segment and element places are used to report the rendering provider’s NPI and name, depending on whether reporting is being done at the header or line level

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = “82”

Rendering Provider Last Name - 2310B (Header)/2420A (Line), Data Element M103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM108 = “XX”

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM109

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2.7. Rendering Providers

Rendering providers must be reported on professional services. There is a new requirement for rendering providers that they must also be reported on laboratory, radiology, injections, supplies, items, and all other services reported on a CMS 1500 format claim.

Even though one may think of a lab code, a radiology code, or other service codes on the claim as not being performed by the physician or physician extender, but rather by a lab or radiology technician, or an injection or other treatment as being performed by a nurse or other staff, the provider overseeing the primary service for the recipient is still to be reported as the rendering provider for these types of services.

Rendering providers may either be reported at the header level (if a single provider is the rendering provider) or at the line level.

In many hospitals, the rendering provider may be a resident, an intern, or a supervised nurse, technician, or other individual not typically enrolled as a provider in their own right. In these situations, the supervising provider may be considered the rendering provider and reported as such.


Referring or ordering providers are to be reported when the service is a result of a referral or an order. It may also be reported at the header level on a claim or at the line level.

Specific Provider Reporting Requirements

Multidisciplinary Team Services

MAD is still working on issues with BH Agencies, Certified Mental Health (MH) Centers, BH Core Service Agencies, Opioid Treatment Centers, Health Homes, and Case Management Agencies, regarding reporting rendering providers on any service which is rendered by a multidisciplinary team. For these providers, for services that are not provided by a multidisciplinary team, the provider must report rendering providers and proceed with enrolling all practitioners on their staffs.

If the rendering provider is a resident, intern, supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right, the supervising provider may be considered the rendering provider and reported as such.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 2: Provider Network</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

Referring and Ordering Providers:

In addition to a rendering provider, the referring or ordering provider may also be reported. For the Medicaid program, MAD does not distinguish between an ordering and referring provide and the information may be placed in either the ordering or referring provider fields. These instructions are for using the referring provider fields.

If the referring, ordering, or prescribing provider is a resident, an intern, a supervised nurse, technician, or other qualified individual who cannot enroll as a provider in their own right, the supervising provider may be considered the rendering provider and reported as such.

Correct Placement of Information

Rendering Physician or Other Provider - Report on all Professional Services

Paper CMS 1500: Report the NPI of the rendering provider in Field Locator 24 J lower line Rendering Provider ID number.

Electronic 837P: The following loop, segment, and element places are used to report the rendering provider’s NPI and name, depending on whether reporting is being done at the header or line level.

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = “82”

Rendering Provider Last Name 2310B (Header)/2420A (Line), Data Element NM103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM108 = “XX”

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM109

Rendering Dentist or Other Provider, Report on Dental Services

Paper ADA form: Report the NPI of the rendering provider in Block 54.

Electronic 837D: The following loop, segment and element places are used to report the rendering provider’s NPI and name, depending on whether reporting is being done at the header or line level.

Rendering Provider – 2310B (Header)/2420A (Line), Data Element NM101 = “82”

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 2: Provider Network</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

Rendering Provider Last Name - 2310B (Header)/2420A (Line), Data Element NM103

Rendering Provider First Name – 2310B (Header)/2420A (Line), NM104

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM108 = “XX”

Rendering Provider’s NPI – 2310B (Header)/2420A (Line), NM109

Referring or Ordering Physicians or Other Provider) - Reported When Applicable

Paper CMS 1500 format: Report the NPI of the referring or ordering provider in Field Locator 17b (Other Physician’s Name and Identifier).

Electronic 837P: The following loop, segment and element places are used to report the referring provider’s NPI and name, depending on whether reporting is being done at the header or line level.

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = “DN”

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider’s NPI – 2310A (Header)/2420F (Line), NM108 = “XX”

Referring Provider’s NPI – 2310A (Header)/2420F (Line), NM109

Referring or Ordering Dentist On Dental Claims - Reported When Applicable

Paper ADA: Form does not have this field. Cannot be reported.

Electronic 837: The following loop, segment and element places are used to report the referring provider’s NPI and name, depending on whether reporting is being done at the header or line level.

Referring Provider – 2310A (Header)/2420F (Line), Data Element NM101 = “DN”

Referring Provider Last Name – 2310A (Header)/2420F (Line), Data Element NM103

Referring Provider First Name – 2310A (Header)/2420F (Line), NM104

Referring Provider’s NPI – 2310A (Header)/2420F (Line), NM108 = “XX”

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	--

Referring Provider's NPI – 2310A (Header)/2420F (Line), NM109



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

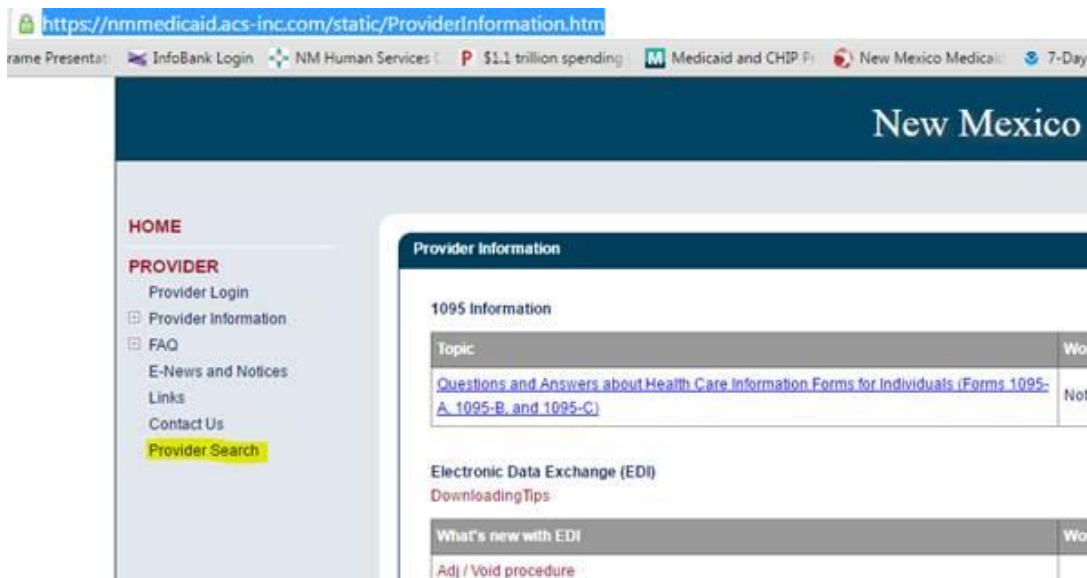
Effective dates: January 1, 2014

2.8. Using the Web to Verify Attending, Ordering, Referring, Rendering or Prescribing Providers

It is ultimately the responsibility of the Medicaid provider billing the service to obtain the NPI of the prescribing, referring, ordering, attending, or rendering provider and to confirm the provider's active enrollment in the Medicaid program. Each Medicaid provider will need to develop its own internal processes to ensure the enrollment requirement is met or the provider risks the claim being denied.

A provider may look up the NPI of a provider participating in the Medicaid program on the Conduent New Mexico Medicaid web portal and may also determine if the attending, ordering, referring, rendering, or prescribing provider is enrolled in the Medicaid FFS or managed care program as required.

1. From the main 'Provider Information' section of the portal
<https://nmmedicaid.portal.conduent.com/static/ProviderInformation.htm>
2. Click on the 'Provider Search' link on the left side of the screen (highlighted in yellow below.)
It can also be accessed directly by going to the URL:
<https://nmmedicaid.portal.conduent.com/webportal/providerSearch>





Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

3. Then search by NPI, organization name, or provider name.

https://nmmedicaid.acs-inc.com/webportal/providerSearch

Present: InfoBank Login NM Human Services \$1.1 trillion spending Medicaid and CHIP New Mexico Medicaid 7-Day Forecast for La DocFinity IntraVIEW

New Mexico Medicaid Portal

Home Contact Us Search GO

INFORMATION
Provider Information
FAQ

WEB REGISTRATION

PROVIDER ENROLLMENT
Enroll Online
Check Enrollment Status
Download Enrollment Application

Provider Search

User would initiate search by selecting one of the following criteria:
* denotes required field(s)

Provider Search

NPI:	<input type="text"/>
Organization Name:	<input type="text"/>
Provider Name: For best results, enter Last Name First Name without punctuation (example: Doe John)	<input type="text"/>

Submit Clear

4. You will get results such as those below.

New Mexico Medicaid Portal

Home Contact Us Search GO

INFORMATION
Provider Information
FAQ

WEB REGISTRATION

PROVIDER ENROLLMENT
Enroll Online
Check Enrollment Status
Download Enrollment Application

Provider Search Results

The most current enrollment information is below. For questions or additional information, contact Xerox Provider Enrollment at 505-246-9988 or 800-299-7304. To contact a specific Managed Care Organization for contract status or other information, please contact:
Molina: Provider Support: 888-825-9266
United Healthcare: Britny Hogan, Provider Installation Specialist UnitedHealthcare Community Plan britny_hogan@uhc.com 505-449-4178
BlueCross BlueShield of NM: Provider Customer Service for Centennial Care : 1-800-693-0663
Presbyterian: Danielle Baca, Contracting Admin Support - Provider Reimbursement Office: 505-923-8584 Fax 505-923-5440 dbaca15@pfs.org

NPI	Organization Name / Provider Name	City / State / Zip	Enrollment Status	Provider Type	Effective Date
1437277670	MARSHALL DANUTA PT	ALBUQUERQUE/ NM/ 87112	Enrolled for Medicaid fee for service and active for managed care - must contact specific managed care organization for contract status	453 Physical Therapist, Lic & Cert	10/01/2002
1346343324	CORRIZ STEPHEN MARSHALL DO	GALLUP/ NM/ 87301	Enrolled for Medicaid fee for service and active for managed care - must contact specific managed care organization for contract status	302 Physician, DO	11/06/2009

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	--

5. In order to be considered to meet the Medicaid FFS or managed care enrollment requirements, a provider must either be “active” as a status 60 or “MCO” as a status 70 on the date of service on the claim.
6. If you do not get any results, re-check the information entered.
7. If you do not find the ordering, referring, or prescribing provider listed, and the individual provider works for the Indian Health Services or a tribal health care facility, an FQHC, or is a resident at University of New Mexico Hospital (UNMH), you can look up the organization using the provider name search field and use the NPI of that entity on the claim.

You can search for an organization by putting part of the organization’s name in the search field. The NPI of an organization such as those listed above may be entered as the prescriber or referring provider.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2.9. Exclusions

At this time, reporting the rendering, referring, ordering, or attending providers on a claim are not required for the following provider types. However, to the extent that an MCO may already be requiring such information, there is no need for the MCO to discontinue the requirement.

Provider Type	Description
221	Indian Health Services Hospital or Tribal Compact facility - special required, multiple specialties allowed
313	Clinic FQHC, Medical
314	Clinic, Rural Health Medical, freestanding
315	Clinic, Rural Health Medical, hospital-based
343	Methadone Clinic
346	Lodging, Meals
363	Community Benefit Provider (enrolled for MCOs only)
401	Ambulance, Air
402	Ambulance, Ground
403	Handivan
404	Taxi, or MCO General Transportation Contractor (Non-Capitated)
462	Case Management Agency (specialty required)

This may change in the future as we work with CMS and providers.

HSD is not addressing value-added services (VAS) at this time. If an MCO feels it is appropriate to notify providers of VAS that a rendering or referring provider or ordering provider is required, an MCO may do so. For example, a physician applying a dental fluoride varnish would reasonably be expected to be identified as a rendering provider; however, this is not stated on any FFS list.

When Medicare or a Medicare Advantage program has paid the claim, and the claim is being evaluated for co-insurance, deductible or co-payment, rendering, referring, ordering, or

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 2: Provider Network</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

attending providers on a claim are not required. However, for any other claim with a prior payment, such as from an insurance company or a health maintenance organization plan, there is no exemption. The provider must add the information to the claim.

If MAD does not enroll certain providers of services that are in managed care, such as Support Brokers, there is no requirement for them to be actively enrolled in Medicaid. If a provider is enrolled or identified with a provider type in the 900 series of provider types, which are only applicable to managed care (such as a traditional healer), there is no current requirement that rendering, referring, ordering, attending providers be reported.

Medicaid is not requiring changes for pharmacy claims at this time. MAD is working on system changes within the State system to meet the Federal requirements for prescriber, but more work is needed. MCOs do not need to remove any requirements on pharmacy claims they may already have in place.

School-based health clinics are not exempt from the requirements. Neither are out of state, out-of-network providers, or single case agreement providers exempt from the rule.

A rendering provider is not required for the Q3014 procedure code, which is paying for the telehealth originating site fee and not for any professional service.

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	------------------------------------	--

2.10. General Information on the Requirements based on Procedure Codes

Each procedure code in the Omnicaid System has an indicator on it that indicates if a rendering provider is required (with an S), a referring provider is required (with an R), or whether both are required (with a B) or if nothing is required (with an N).

A list of codes with the indicators is periodically provided to each MCO which includes most codes on the Rendering Provider Required by Procedure Code List.

However, there are some important considerations in using that list:

1. Referring Requirements for Laboratories, Radiology Facilities, Suppliers of Prosthetics and Orthotics, OME, and Medical Supplies

The indicator on the procedure code list is not applicable to services billed by laboratories, radiology facilities, prosthesis and orthosis suppliers, oxygen suppliers, durable medical equipment and medical supply suppliers.

For these providers there is always an expectation that the services were ordered and therefore the ordering provider must be indicated.

Therefore, for example, the indicator on a lab code that says a rendering provider is required does not apply to these providers, not even the free standing laboratory. Rather, the requirement that there should always be a referring provider is applicable.

For a laboratory or radiology facility, a rendering provider would only be required when a professional interpretation billed (typically using modifier 26).

For claim processing and encounter purposes MAD does not make a distinction between referring or ordering providers. Either will meet the requirements when a referring provider is required.

2. Rendering Provider Requirements

The Rendering Provider Required by Procedure Code List described above may be used to determine when a rendering provider is required. However, there are other aspects to be considered, such as the billing provider type.



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

The following provider types are always exempt from reporting a rendering provider. This may change in the future, but until individuals working within these providers are always enrolled, we cannot enforce a rendering provider requirements:

Provider Type	Description
218	Treatment Foster Care Services
221	Indian Health Services Hospital or Tribal Compact facility
324	Nursing, Private Duty
334	Optician
336	Orthotist
337	Prosthetist
338	Prosthetist & Orthotist
343	Methadone Clinic
344	HCBS or Mi Via Self-Directed Waivers
346	Lodging, Meals
363	Community Benefit Provider
405	Birthing Centers
412	Hearing Aid Supplier
414	Medical Supply Company
415	IV Infusion Services
416	Pharmacy
417	Pharmacy, Rural Health Clinic (RHC)
441	Developmental Delay Services
447	Renal Dialysis Facility
462	Case Management Agency



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

For clarity, MAD has prepared a list of all FFS provider types for which a rendering provider may be required (Rendering Provider Required by Provider Type List). If the provider is on this list, and the procedure code is on the Rendering Provider Required by Procedure Code List, a rendering provider should be reported.

The rendering provider cannot be the same as the billing provider if the billing provider is a group.

- A billing group provider number cannot be used as the rendering provider on the claim. There may be various ways of enforcing this.

However, MAD has always designated whether a provider is a group practice or an individual. Most individual health professionals can belong to a group practice or practice individually. When it is possible for a provider ID to be either a “group” (G) or an “individual” (I), MAD is careful when processing an application to designate the provider as either G or I.

This information is used when validating a rendering provider entered on a claim. Assume there is a professional group such as Scrooge and Marley Pediatricians with a G indicator and there is an individual within the group “Dr. Jacob Marley” with an I indicator.

If the billing provider Scrooge and Marley Pediatricians also enters their group NPI number in the rendering provider field, the Medicaid Management Information Systems (MMIS) will detect the rendering provider is the same as the billing group and deny the claim.

If the billing provider is an individual, Dr. Bob Cratchit, for example, and the NPI appears as both the billing provider and the rendering provider, the MMIS will recognize that the billing provider is an individual and therefore may certainly use the individual NPI in the rendering provider field. (This is done by using by-pass logic in the edit.)

In the MMIS, the billing provider is propagated to the lines of the claim.

- This principle remains exactly the same for dental individual providers and dental group practices.

Not all providers can be designated as a G and having many employees does not make a provider a group. The G distinction is largely for professional providers and the groups they form. Institutional providers such as hospitals are considered I, not as group, as is a hospice or an HHA – that is, they only function as individual entities.



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

The only exception is the FQHC because it is a clinic and a clinic is considered a group practice. Depending on how the MCO processes Comprehensive Outpatient Rehabilitation Facility claims, such as if they use the UB format, there is a requirement for rendering providers to be identified for them.

- One of the major new requirements for Medicaid is the rendering provider must be reported for outpatient hospital services billed on the outpatient hospital claim.
- Behavioral Health Codes Exempted from Reporting Rendering Provider

It is anticipated that many of the BH codes listed below will, at some point, require a rendering provider. Until there has been further communications with the providers, MAD will not require a rendering provider for the following. A chart showing the rendering provider requirements for BH services will be periodically updated and sent to the MCOs.

Note that for clarity, MAD will periodically send the MCOs lists of all codes that do and do not require a rendering provider. Also, a transportation provider never has to identify a rendering provider.

Note that if a MCO is already requiring rendering providers for these codes, there is no need for a MCO to stop doing so.

Also, please do not use this list to try to determine which codes are a benefit of the program. That is a different issue. We do not necessarily cover all the codes described above.

3. Attending Provider Requirements by Provider Type

The following providers require an attending provider. A rendering provider is never required unless the provider is not the facility, but rather a practitioner billing on the CMS 1500 form such as for skilled nursing facility (SNF) rehabilitation services, for example.

Provider Type	Description
201	Hospital, General Acute Inpatient
202	Hospital, Rehabilitation Unit in a General Acute Hospital Inpatient
203	Hospital, Rehabilitation or Other Specialty Hospitals- such as LTAC hospitals - Inpatient
204	Hospital, Psychiatric Unit In A General Acute Hospital Inpatient



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Provider Type	Description
205	Hospital, Psychiatric Free Standing Inpatient
211	NF, Private For NF Stays
212	NF, State For NF Stays
213	Hospital, Swing-Bed For NF Stays
216	ARTC, Joint Commission accredited for Residential Facility Stays
217	RTC, not Joint Commission accredited for Residential Facility Stays
219	RTC Group Home, not Joint Commission accredited for Residential Facility Stays

The attending provider cannot be the same as the billing provider and must be an individual provider. The MMIS has edits that enforce this requirement.

4. The Referring Provider by Provider Type

The requirements for referring providers on some claims is covered in number 1, above. A referring provider is required from the following unless otherwise exempted in this document (such as when we say that Medicare cross overs are exempt from the requirement).

Provider Type	Description
351	Lab, Clinical Freestanding
352	Radiology Facility
353	Laboratory, Clinical with Radiology
354	Diagnostic Laboratory (physical measurements)
414	Medical Supply Company
415	IV Infusion Services
416	Pharmacy when billing on a CMS 1500 format
417	Pharmacy, RHC when billing on a CMS 1500 format
451	Occupational Therapy (OT) (may self-refer)
452	Occupational Therapist Licensed, not certified (may self-refer)



Section 2: Provider Network

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Provider Type	Description
453	Physical Therapy (PT) (may self-refer)
454	Physical Therapist, Licensed, not certified (may self-refer)

Additional circumstances for which a referring provider is required are as follows:

Provider Type	Description
324	Nursing, Private Duty - referring is required when not being billed by an HHA
334	Optician - a referring provider must be indicated for glasses but not for repairs

Other providers are to report a referring provider when there is one, but generally unless the MCO specifically requires a referring provider for a service, it is not known whether the service was due to a referral.

However, the following procedure codes would seem to logically have a referring provider so it must be reported for them:

Description	Procedure Code	Requirement
Office Consultation	99241	R-Referring
Office Consultation	99242	R-Referring
Office Consultation	99243	R-Referring
Office Consultation	99244	R-Referring
Office Consultation	99245	R-Referring

At this time, CMS rules allow Medicaid to accept the referring provider can be an institution and not necessarily an individual. This is generally allowed when the referring provider is with a type of institution such as UNMH, an IHS facility, or tribal facility where interns, residents, and non-enrolled staff might be practicing. MCOs must also allow for this.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	--

2.11. Appendices

2.11.1 Notification of Change in Services – Notification of Transition

2.11.2 Narrative For

2.11.3 Transition Plan A

2.11.4 Transition Plan B

	Section 2: Provider Network	Revision dates: August 15, 2014; March 3, 2015 Effective dates: January 1, 2014
---	------------------------------------	---

2.11.1. Notification of Change in Services – Notification of Transition

NOTIFICATION OF CHANGE IN SERVICES

NOTIFICATION OF TRANSITION

*Expected Change *Unexpected Change

Date:

Date MCO Notified of Closure:

Anticipated Date of Closure:

Name of Provider or Facility:

Type of Provider Individual:
Group:
Agency
Facility:

Full contract termination? Yes No

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

Satellite location terminating? Yes No

Address of location terming (include county and region type):
Type(s) of Service(s) at location:

Terminating Services only? Yes No

Type(s) of Service(s):

Total Number of Members Affected: <21 >21

Transition Plans Required? Yes No

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

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

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

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



Section 2: Provider Network

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

Effective dates: January 1, 2014

* Notification of unexpected change is due within five business days of confirmed change. Notification of expected change is due 30 days prior to the confirmed change.
CC 2014, Revised: 02/2017



Section 2: Provider Network

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

Effective dates: January 1, 2014

2.11.2. Transition Plans Narrative

Narrative For

[Empty box for provider/facility name]

MCO Staff and/or Care Coordinator: Date:

[Empty box for MCO Staff and/or Care Coordinator: Date]

(Provider/Facility Name)

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

[Empty box for describing reasons/circumstances]

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

[Empty box for describing impact on services]

The MCO's plan for maintaining access and the quality of Member care:

Please explain all factors considered in making the determination that the change will not significantly impact the system and provide assurances that all Members will be transitioned to new providers (if applicable).

[Empty box for MCO's plan for maintaining access and quality]

Transition issues identified

[Empty box for transition issues identified]



Section 2: Provider Network

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

Effective dates: January 1, 2014

2.11.3. Transition Plan A

Overall Transition Plan Information

**MCO Transition Plan For
(Provider Name) (Date)**

	MCO task assignment	Comments	Begin Date	End Date
1. Preplanning				
MCO receives communication of contract, location, service closure.				
Closing program sends a formal letter to MCO advising of closing.				
List of affected members sent to MCO.				
List of special problems expected or associated with transition.				
MCO letter to affected members offering assistance (as needed).				
2. Network Operations				
Contracting department to complete Table A Provider Information.				
3. Transition planning				
Meeting with program or director.				
Complete plan to ensure program is appropriately referring and transitioning affected members.				
Progress updates of transition program.				
Template for Records Retention Completed and attached.				



Section 2: Provider Network

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

Effective dates: January 1, 2014

	MCO task assignment	Comments	Begin Date	End Date
4. Communication to HSD				
Submit notification.				
Submit narrative.				
Submit Transition Plan A.				
Submit Transition Plan B.				
Bi-weekly updates of transition plans and narrative from MCO to state agency contact person.				
5. Care Coordination				
Identify Care Coordinators to be contact point for members seeking assistance.				
Care Coordinator review of community resources.				
Care coordination and MCO Clinical/UM Department tasks.				
Compile weekly report of care coordination.				
Meeting with MCO and program transition team to coordinate efforts, if applicable.				
Other requirements as needed depending on circumstances of closing.				
Transition plan finalized.				



Section 2: Provider Network


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

Effective dates: January 1, 2014

MCO certifies the transition of all members has taken place and is finalized.

Signature:

Date:

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 3: Member Education</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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3. Member Education


3.1. Policies and Procedures

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


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

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

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

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 3: Member Education	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	------------------------------------	--

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

	Section 3: Member Education	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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3.2. Member Handbook

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

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



Section 3: Member Education

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Information regarding Grievances, Appeals, and Fair Hearing procedures and timeframes including all pertinent information provided in 42 CFR 438.00 through 438.424;
- Information on the member's right to terminate enrollment and the process for voluntarily dis-enrolling from the plan;
- Information on the MCO switch process;
- Information on how members change their demographic information.
- Information regarding advance directives including advance directives for BH;
- Information regarding how to obtain a second opinion;
- Information on cost sharing, if any;
- How to obtain information, upon request, determined by HSD as essential during the member's initial contact with the MCO, which may include a request for information (RFI) regarding the MCO's structure, operation, and physician's or senior staff's incentive plans;
- Value-added benefits which are not covered by the Agreement and how the member may access those benefits;
- Information regarding the birthing option program;
- Language that clearly explains that a Native American member may self-refer to an IHS or a tribal health care facility for services;
- Information on how to report fraud, waste and abuse;
- Information on member's privacy rights;
- Information on the circumstance/situations under which a member may be billed for services or assessed charges or fees; specifically that the provider may not bill a member or assess charges or fees except: if a Member self-refers to a specialist or other provider within the network without following contractor procedures (e.g., without obtaining prior authorization) and the contractor denies payment to the provider, the provider may bill the member, if a provider fails to follow the contractor's procedures, which results in non-payment, the provider may not bill the member, and if a provider bills the member for non-covered




Section 3: Member Education

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

services or for self-referrals, he or she shall inform the member and obtain prior agreement from the member regarding the cost of the procedure and the payment terms at time of service;


- Information on how to access services when out of state;
- Include information about Care Coordination, including the role of Care Coordinators; and
- Information on the centennial rewards program and how a member accesses the program and earns rewards.

	Section 3: Member Education	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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3.3. Provider Directories

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


Online provider directories must be comprehensive and inclusive of all providers in all regions, as well as telephone numbers for crisis lines, Member Services line, and all out of state providers.

	Section 3: Member Education	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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3.4. Member Identification Card

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

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

	Section 3: Member Education	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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3.5. Member Advisory Board

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

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

The MCO’s Member Advisory Board shall keep a written record of all attempts to invite and include its members in its meetings. The Member Advisory Board roster and minutes shall be made available to HSD 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 10 calendar days in advance of meetings to be held.

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

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



Section 4: Care Coordination


Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

4. Care Coordination

4.1. General Information

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. Care Coordination strategies will be analyzed for effectiveness and appropriate changes made. Any issues or concerns will be addressed immediately.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.2. Care Coordination Functions

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

- Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and who are not currently identified for Care Coordination Level 2 or 3 services;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
- Administer the Community Benefit Service Questionnaire (CBSQ) as applicable (see Section 4.5 CBSQ);
- Semi-annual or quarterly in-person visits with the member;
- Quarterly or monthly telephone contact with the member;
- Comprehensive Care Plan (CCP) development and updates; and
- Targeted Health Education, including disease management, based on the member's individual diagnosis (as determined by the CNA).

MCOs may delegate care coordination functions in the following instances:

- MCOs that own and operate patient-centered medical homes (PCMHs) as part of their provider network may delegate to such PCMHs, provided the PCMH Care Coordinator is employed by the MCO;
- MCOs may delegate all primary care coordination functions to a designated Section 2703 Health Home, provided the Health Home is determined ready by the Health Home Steering Committee to perform such functions;
- MCOs may fully delegate care coordination to providers/health systems in a value-based purchasing (VBP) arrangement that outlines a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes; and/or
- MCOs may delegate the HRA, CNA, care coordination touch points with high need members, coordination of referrals, linking Members to community services, and locating

 <p>HUMAN SERVICES</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	--	--

and engaging with Unreachable and Difficult to Engage Members as part of the Shared Function Model with entities or individuals for a mutually-agreed upon reimbursement rate.

The MCOs may not delegate the NF level of care (LOC) assessment and may not delegate care coordination for members who are in the SDCB model.

The MCO, through its care coordination monitoring of MCO staff and care coordination delegates, will ensure, at a minimum:

- 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 such as inter-rater reliability) to determine effectiveness and appropriateness of processes.
- Competencies will be evaluated in the following areas, but not limited to:
 - LOC assessments and reassessments occur on schedule in compliance with the Agreement and are submitted to the lead or supervising Care Coordinator;
 - CNAs and reassessments, as applicable, occur on schedule in compliance with the contract;
 - Care plans are developed and updated on schedule in compliance with the Agreement;
 - Care plans reflect needs identified in the CNA and reassessment process;
 - Care plan goals are member-centric, and agreed-upon by the member;
 - Care plans are appropriate and adequate to address the member's needs including the need for all Community Benefit (CB) services;
 - Services are delivered as described in the care plan and authorized by the MCO;
 - Services are appropriate to address the member's needs:
 - Services are delivered;
 - Service utilization is appropriate;
 - Service gaps are identified and addressed;
 - Minimum Care Coordinator contacts are conducted;



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Care Coordinator-to-member ratios are appropriate;
- 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; and
- CBSQ is administered as appropriate.
- The MCO, or its delegate, 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 Agreement and the MCO's policies and procedures. The functionality will include but not be limited to the ability to:
 - Capture and track enrollment dates, 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 LOC and needs reassessment, date of each update to the care plan, and dates regarding transition from an institutional facility to the community;
 - Capture care coordination level assignments and track compliance with minimum care coordination contacts as specified in the Agreement;
 - Notify the Care Coordinator of eligibility end date, date for annual LOC reassessment, date of comprehensive needs reassessment, and date to update the care plan;
 - Capture and track eligibility/enrollment information, LOC assessments and reassessments, and needs assessments and reassessments;
 - Capture and monitor the care plan;
 - Track requested and approved service authorizations, including Covered Services and VAS, as applicable;
 - Document all referrals received by the Care Coordinator on behalf of the member for Covered Services and VAS, as applicable, needed in order to ensure the member's health, safety and welfare, and to delay or prevent the need for more expensive institutional placement. Include notes regarding how such a referral was handled by the Care Coordinator, including any additional follow up;
 - 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;




Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Track service delivery against authorized services and providers;
- Track actions taken by the Care Coordinator to immediately address service gaps;
- Document case notes relevant to the provision of care coordination; and
- Allow HSD or its designee to have remote access to case files.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.3. Health Risk Assessment

The MCO or its delegate shall conduct HSD standardized HRAs on all members who are newly enrolled in Centennial Care for the purpose of: introducing the MCO to the member, obtaining basic health and demographic information about the member, and confirming the need for a CNA to determine if the member should be assigned to care coordination level 2 or level 3. The MCO may assign a member for care coordination without completion of a CNA, provided they obtain HSD approval in advance of the level assignment.

The standardized HRA (Section 4.15.1.) will be completed for each new Centennial Care member within 30 calendar days of the member’s enrollment in the MCO. Additionally, an HRA will be completed upon a change in the member’s health condition if the member is not in care coordination level 2 or level 3. The HRA may be conducted by telephone, in person, or as otherwise approved by HSD; HRA information must be obtained from the member or the AR and must be documented in the member’s file. The MCO shall ensure its staff, subcontractors, or vendor(s) conducting the HRA are adequately trained to effectively conduct the HSD standardized HRA.

The MCO or its delegate will make reasonable efforts to contact members to conduct an HRA and provide information about care coordination. Such efforts shall include, but not be limited to, engaging community supports such as Community Health Workers (CHWs), Community Health Representatives (CHRs), Core Service Agencies (CSAs), and Centers for Independent Living. The MCO or its delegate shall document at least three attempts to contact a member which includes at least one attempt to contact the member at the most recently reported phone number. The three 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 attempts shall be included in the member’s file. Such attempts shall occur on not less than three different calendar days, at different hours of the day, including day and evening hours and after business hours.


After these attempts have been made and documented, and if the member has not been engaged, the member is categorized as “Unreachable” and is not assigned to care coordination level 2 or level 3. The MCO will conduct quarterly claims mining for these members and will renew attempts to reach the member if claims indicate a possible need for care coordination.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

If the MCO has made three documented attempts to contact and has reached the member at least once, but the member fails to engage with the completion of the CNA, the member is categorized as “Difficult to Engage” (DTE) and is not assigned a care coordination level 2 or level 3. If the member is categorized as a care coordination level 2 or level 3 based on the most recent CNA but fails to engage in two consecutive contract required touch points (telephonic or in person), the member is then categorized as DTE, with appropriate documentation in the member’s file. The MCO will continue attempts to reach the member quarterly or until the member has signed, or has documentation of refusing to sign, the care coordination declination form.

The HSD standardized HRA includes the following information:

- Member demographics
 - Member name, address, telephone number, date of birth;
 - Member Medicaid number;
 - Names and relationship of person(s) completing form (other than member);
 - Emergency contact and telephone number;
 - HRA date; and
 - Assessment Method and Type.
- Member Health Information
 - Language preference, translation needs, and special preferences (cultural, religious, physical);
 - Main health concern;
 - Current or past PH and BH conditions or diagnoses, including brain injury;
 - Pending PH or BH procedures;
 - Most recent physical examination and/or recent medical appointment;
 - Emergency room visits, including reason, number of visits and dates of visit(s);
 - Number of hospital stays in past 6 months, and any readmissions;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--


- Indication of a 1915(c) waiver LOC assessment or client individual assessment (CIA);
- Number of medications;
- Living situation;
- Assistance with two or more activities of daily living (ADL) and type of need;
- Interest in and need for LTC services;
- Advance directives preference and interest in receiving information; and
- Interest in receiving care coordination.

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

- The purpose of care coordination;
- The care coordination levels (CCLs);
- Notification of the member’s right to request a higher CCL;
- Requirement for an in-person CNA for the purpose of providing services associated with CCL2 or CCL3; and
- Specific next steps for the member.

Within seven calendar days of completion of the HRA, all members shall be informed of the need for a CNA. MCOs may request to add additional questions to the HRA to meet the requirements of regulatory and accrediting bodies by submitting the additional questions and the reason(s) for inclusion for State approval. Requests must be sent for approval to HSD/MAD through the MCO’s Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

The HRA and the CNA may be performed concurrently.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	-------------------------------------	--

4.4. Comprehensive Needs Assessment

A CNA is conducted for Medicaid members eligible for managed care who are identified through the HRA as having significant health conditions and risk indicators signifying the potential need for CCL2 or CCL3. The MCO shall schedule a CNA within 14 calendar days of completion of the HRA and complete the CNA within 30 calendar days of completion of the HRA unless the member is in a model approved for delegated care coordination functions with other State-approved guidelines.

Members who are identified as not needing a CNA shall be monitored by the MCO care coordination unit quarterly through predictive modeling software and available utilization and claims data to determine if the member had a change in health status and is in need of an HRA or CNA.

For members who reside in an NF, rather than conduct a CNA, the MCO shall ensure the Minimum Data Set (MDS) is completed and collect supplemental information related to BH needs and the member's interest in receiving CB services.

For members who have indicators that may warrant an NF LOC, the MCO Care Coordinator shall conduct an in person, in home CNA at the member's primary residence. The MCO shall use the New Mexico Medicaid NF LOC Criteria and Instructions to determine NF LOC for members.

The CNA is the sole responsibility of the MCO Care Coordinator unless delegated to another entity via a Shared or Full Delegation Model.

CNAs must be performed through the utilization of an assessment tool that has been approved by HSD for assessing the member's medical/PH, BH, LTC, 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 30 calendar days prior to use by the MCO or its delegate.

The CNA must be conducted in the member's primary place of residence or facility for members reintegrating back into the community. The MCO or its delegate will involve collateral respondents when scheduling the CNA, including family members, caregivers, CHRs, CHWs,

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

and/or other significant social support individuals, with the consent of the member. The MCO or its delegate must evaluate the need for translation, including signing or communication boards when scheduling the CNA.


CNAs must be conducted face-to-face with the member and collateral parties in the home, unless an exception has been granted by HSD. Home setting is defined as the primary residence for the member in the community where there is an identifiable address, and the member is residing for an established period of time for shelter, safety, physical assistance, recovery, legal requirements, or treatment services.

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

- If the member is homeless, or in a transition home and the assessment can be conducted in a private setting at a location, mutually agreeable to the member, such as a church meal site program, community non-profit organization center, community MH agency, food bank site, etc.;
- If the member is currently part of the jail-involved population preparing for release; or
- If the Member is in a Health Home or being served by a provider approved for a Full Care Coordination Delegation Model.

Other requests for exceptions to the CNA face-to-face or in the member's home setting requirements must be made directly to HSD by the MCO using the following process:

- Complete the Centennial Care CNA Exception Request form (MAD 601);
- Alternate locations must be submitted to HSD for review and should be assessed for privacy to ensure the member's Protected Health Information (PHI) is not jeopardized;
- Send the completed MAD 601 by secure email to: HSD-QB-CCU-CNA@state.nm.us;
- HSD will review the request and respond to the specific MCO requestor within two business days;
- If an exception is approved, it shall only be valid for six months, or until the next CNA is needed, whichever comes first; and

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	-------------------------------------	--

- Requests **will not** be reviewed or approved if submitted:
 - Via unsecure email;
 - To an email address other than HSD-QB-CCU-CNA@state.nm.us; and
 - Via any format other than the MAD 601 Form.

All efforts must be made to negotiate with and educate the member about the importance of participating in the completion of a CNA. The MCO or its delegate 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, includes determination of: any structural problems for member’s mobility access; need for safety enhancements, such as smoke detectors, fire extinguishers, ramps, guard rails, and bathroom equipment; fall prevention concerns such as throw rugs; doorway access for wheelchairs; 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 areas of considerations include assessing for rodent/pest infestation, fire hazards due to electrical wiring issues and clutter/hoarding, as well as outdoor hazards due to overgrown weeds and undergrowth of yards/trees. The practice of conducting in home CNAs further allows for observation of the existence of other parties living in the home and possibly presenting support or risk to the member.

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 this assessment makes the determination of useful resources to meet the member’s needs, such as the CB for personal care assistance, special home environment modifications and adaptive equipment. The MCO will ensure the member signs the HSD-approved care coordination declination form and maintain the signed form in the member’s file. If the member refuses to sign the care coordination declination form, the MCO shall document such refusal in the member’s record. The MCO will perform quarterly claims mining for these members and will renew attempts to reach the member if claims mining indicates a possible need for care coordination. The member

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

who has refused care coordination will not be assigned to care coordination level 2 or level 3. In documented refusal circumstances, the MCO will submit a proposal to the member outlining a basic care plan with minimum services outlined and suspend any requests for increased services/personal care hours until a CNA and NF LOC is conducted and completed.

At a minimum, the CNA shall:

- Assess PH and BH needs, including but not limited to: current diagnoses; history of significant PH and BH events, including hospitalizations and emergency room visits; medications; allergies; providers involved in member’s care; DME; brief substance abuse screening questionnaire, as approved by HSD/BHSD and history; family medical and BH (MH 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 ADL (mobility, grooming, bathing, eating, dressing, medications (i.e., self-administration and safety) and instrumental activities of daily living (IADLs)/ADLs (i.e., money management, meal preparation, housekeeping/cleaning, emergency awareness and preparedness, grocery shopping).
- Assess LTC needs including but not limited to: environmental safety including items such as smoke detectors; pests/infestation; trip and fall dangers; and adaptive needs such as ramps or other mobility assistance. If the member is eligible for the CB, the MCO shall assess for all CB services.
- Include a risk assessment, using a tool and protocol approved by HSD, as applicable. A risk agreement that shall be signed by the member or his/her representative 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.
- Assess disease management needs, including: identification of disease state; need for targeted intervention and education; and development of appropriate intervention strategies.
- 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,



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

such as senior companion services, meals-on-wheels, etc.; living environment (related to health and safety); Individualized Education Plan; and Individualized Service Plans for Developmental Disabilities, Medically Fragile (MF), or Mi Via Waiver Program recipients, (if applicable).

- 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.
- Identify cultural information, including language and translation needs and utilization of ceremonial or natural healing techniques.
- Ask the member for a self-assessment regarding their viewpoint of their condition(s) and service needs.
- In the event the member is a minor under the age of 18, identify the parent or legal guardian participating in and/or responding for the minor during assessment.
- In the event the member is receiving the Alternative Benefit Plan (ABP) and meets the definition and criteria of Medically Frail or is otherwise ABP Exempt, notify the member that he/she may be exempt, explain the difference in benefits and facilitate his/her transition to the ABP Exempt benefit package at the member's choice.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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4.5. Community Benefit Service Questionnaire

As part of the CNA process, MCO Care Coordinators must administer the CBSQ. The CBSQ assists the Care Coordinator in discussing all available CB services with the member, and the Community Benefit Member Agreement (CBMA) elicits the member's participation in identifying risks.


The completed CBSQ and the CBMA are considered part of the member's CNA. The MCOs must ensure all Care Coordinators are trained in administering these documents.

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

- Allocated members receiving their first CNA, including members who are in the process of community reintegration from an NF.
- Annually for members with a current NF LOC (see note about CCL3 members below).
- Full Medicaid members without an NF LOC who request CB services.
- Full Medicaid members without an NF LOC who have not requested CB service but appear to meet NF LOC criteria during the CNA.

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

- Members who have not previously met an NF LOC and who are not requesting CB at the time of the CNA.
- Members who may meet an NF LOC for a short period of time due to a clinical episode (i.e., pregnancy).
- Members not being assessed for an NF LOC.
- Members on the DD, Mi Via, or MF Waivers (categories of eligibility [COEs] 095 and 096).
- Members in an NF (unless in the process of being allocated through community reintegration or member has a COE (i.e., Supplemental Security Income [SSI]) that deems them eligible to reintegrate without a waiver allocation).
- Members who decline assessment for NF LOC or refuse CB services. The MCO Care Coordinator must document the refusal in the member's record.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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CCL3 members:

- For all members with CCL3 and an NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the Care Coordinator.
- For members with CCL3 but without an NF LOC, follow the criteria above.

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


	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.6. CNA 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 LOC coordination may be needed.

Additional CNAs may also be conducted, as the Care Coordinator deems necessary, as requested by the member, provider, family member or legal representative, or as a result of a change in health status and/or social support situation.

Specific indicators warranting a need for conducting a new CNA may include but are not limited to: significant changes in member’s medical and/or BH condition (decline or improvements in health status); changes in setting of care (SOC), such as hospitalization, rehabilitation and/or short-term NF admission (long-term NF 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 New Mexico Children, Youth & Family Department (CYFD) interventions; and changes in the amount of caregiver services requested and requested amount exceeds the range of hours corresponding with member’s existing assessment score. These events may at times not require a new CNA be completed. If a new CNA is not conducted, the member’s record should clearly establish why the triggering event did not result in the MCO conducting a new CNA. The decision can be made via telephone contact or face to face visit with the member.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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4.7. Comprehensive Care Plan Requirements

This policy is in conjunction with all elements described in the CCP Requirements outlined in the Agreement, which defines the processes for development, implementation and management of a care plan for all members in levels 2 and 3 of care coordination. The MCO- or HSD-approved designee is responsible for ensuring a CCP is initiated upon enrollment and must oversee the Care Coordinator who is responsible for coordinating all services in the CCP.

- **CCP Scope and Process.** The MCO- or HSD-approved designee must establish a process to ensure coordination of care for members that includes:
 - Coordination of the member’s PH, BH, and long-term health care needs through the development of the CCP;
 - Collaboration with the member, member’s friends and family (at member’s request), member’s PCP, specialists, BH 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;
 - With the member’s consent to share information, the care plan should be shared and utilized by those involved in providing care to the member (e.g., BH providers should be aware and take into consideration the member’s PH care issues when working with the member); and
 - Verification of all decisions made regarding the member’s needs and services, and ensures all information is documented in a written, CCP.
- **CCP Development and Management:**
 - The CCP is in a language the member and or/family member can understand. The member shall lead the person-centered planning process to ensure the CCP is member-centric and agreed upon by the member;
 - The member may designate his/her representative to have a participatory role, as needed, and as defined by the member, unless the representative has decision making authority, under law; and



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The MCO or HSD approved designee shall develop and authorize the CCP within 14 business days of completion of the CNA unless the member is in a health home and/or using the Treat First model of care.
- The Care Coordinator shall:
 - Ensure the member or member's legal representative understands, reviews, signs and dates the CCP.
 - Provide a copy of the completed CCP to the member, member's legal representative as applicable or other providers authorized to deliver care to the member in a format that is easily readable (e.g., 12 font).
 - With the member's consent, confirm family, providers, or any other relevant parties are included in the treatment and planning of the member's CCP.
 - Ensure timelines for the development and implementation and/or update the CCP are met.
 - Facilitate treatment and coordinate with providers to assist the member and his or her family with navigating the system including scheduling appointments, arranging transportation, or advocating for the member as needed.
 - Verify services have been initiated and/or continue to be provided as identified in the CCP and ensure services continue to meet the member's needs.
 - With member's consent, maintain appropriate, constant communication with community and natural supports to monitor and support their ongoing participation in the member's care.
 - Identify, address, and evaluate service gaps to determine their cause and minimize any gaps going forward and ensuring back-up plans are implemented and effectively working; including strategies for solving conflicts or disagreements, and provide clear conflict-of-interest guidelines for all planning participants.
 - Identify and list specific risk factors and changes to member's risk, address those changes and update the member's risk agreement and CCP as necessary to include measures to minimize the identified risks.



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Inform each member of his or her Medicaid eligibility status and end date and assist the member with the process for eligibility redetermination.
- Educate members with identified disease management needs by providing specific disease management interventions and strategies.
- 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.
- Educate member about non-Medicaid services available as appropriate (e.g., Adult Substance Abuse Residential Treatment, Detoxification, Home Delivered Meals, and Infant MH).
- Reflect cultural considerations of the member and conduct the CCP process in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Required Elements of a CCP include the following:
 - Pertinent member demographics and enrollment data.
 - 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.
 - Covered medical diagnosis, past treatment, previous or pending surgeries (as applicable), medications and allergies.
 - Member's current status, including present levels of function in physical, BH cognitive, social, and educational domains.
 - Member or family barriers to receiving treatment, such as a member or family member's inability to travel to an appointment.
 - Identify the member or family's strengths, resources, priorities, and concerns related to achieving mutual recommendations made in caring for the member.
 - Services recommended achieve the identified objectives, including provider(s) or person(s) responsible and timeframes for meeting the member's desired outcomes.



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Identify 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.
- An interdisciplinary team, with member's consent, including but not limited to: the Care Coordinator; social worker; registered nurse (RN); medical director; PCP; and others must be identified to develop, implement and update the CCP as needed.
- Reflect the setting in which the individual resides is chosen by the member, and is integrated in and supports full access of members receiving HCBS, to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
- Reflect the member's strengths and preferences.
- Identify goals and desired outcomes that reflect the services and supports (paid and unpaid) that will assist the member to achieve identified goals, and include who will provide the services and supports.
- Identify goals and preferences related to relationships, community participation, employment, income and savings, health care and wellness, education and others.
- Include services and, the purpose or control of which the member elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.
- CCP Revisions
 - The CCP will be revised when the member experiences one of the following circumstances:
 - Risk of significant harm: within one business day of the MCO receiving notification, the care coordination team will convene, in person or by teleconference; and if necessary the care plan will be modified accordingly within 72 hours;



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Major medical change;
 - The loss of a primary caregiver or other significant person;
 - A serious accident, illness, injury or hospitalization that disrupts the implementation of the CCP;
 - Serious or sudden change in behavior;
 - Change in living situation, including out-of-home placements and subsequent discharges;
 - Proposed change in services or providers (e.g. CB);
 - It has been confirmed by APS or CYFD that the member is a victim of abuse, neglect, or exploitation;
 - Any team member requests a meeting to propose changes to the CCP;
 - Criminal justice involvement on the part of the member (e.g., arrest, incarceration, release, probation, parole); or
 - As requested by HSD.
- Within five business days of completing a reassessment of a member's needs, the Care Coordinator shall update the member's CCP as appropriate, and the MCO or HSD approved designee shall authorize and initiate services in the updated CCP.
- Ongoing Care Coordination
 - This policy along with all elements described in Ongoing Care Coordination outlined in the Agreement, defines how the MCO or HSD approved designee shall perform real time and ongoing care coordination to ensure all members receive the appropriate care.
 - Ongoing care coordination functions shall include all elements defined in the Agreement including the following:
 - Identify gaps and address the needs of the member, including develop and/or update the care plan as needed.




Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Ensure when a member's LOC coordination increases or decreases that continuity of care is always maintained.
- Maintain a single point of contact for the member to ensure coordination of all services and monitoring of treatment.
- Maintain face-to-face and telephonic meetings with the member to ensure appropriate support of the member's goals and foster independence.
- 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.
- Education regarding service delivery through Medicare and/or Medicaid.
- Measure and evaluate outcomes designated in the CCP and monitor progress to ensure covered services are being received and assist in resolution of identified problems.
- Achieve coordination of physical, BH, and LTC services.
- Maintain consistent communication and contact with member's PCP, specialists, and other individuals involved in the member's care.
- Maintain and monitor the member's CB and provide assistance with complex services.
- Consider member and provider input to identify opportunities for improvement.
- Collaborate and/or cooperate with representatives of the Independent Consumer Support System.


	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.8. Staffing Requirements and Delegations

The MCO may utilize a care coordination team approach to perform care coordination activities, with the MCO’s care coordination team consisting of the member’s primary Care Coordinator and other individuals with relevant expertise and experience appropriate to address the needs of members. While the MCO may subcontract the HRA activities, the MCO shall ensure its staff, subcontractor(s), or vendor(s) conducting the HRA are adequately trained to effectively conduct the HSD standardized HRA. CNAs must be performed by primary Care Coordinators employed by the MCO or its delegate. The MCO may delegate some care coordination functions to local resources, such as: PCMHs, FQHCs, CHWs, CHRs, school-based health centers [SBHCs], Correctional Facilities, CSAs, Paramedicine programs, county entities, Centers for Independent Living, and Tribal entities. The MCO will implement policies and procedures that will define and specify the qualifications, experience, and training of each member of the MCO care coordination team and its delegated Care Coordinators to ensure specific functions are performed by a qualified Care Coordinator.

Maximum caseload per Care Coordinator, are established by HSD and shall not be exceeded by the MCO. As the MCO transitions more care coordination functions to the provider level, it will collaborate with HSD to adjust care coordination caseload requirements. Caseload to Care Coordinator ratios are as follows:


- CCL2:
 - Members not residing in an NF 1:75; and
 - Members residing in an NF 1:125.
- CCL3:
 - Members not residing in an NF 1:50; and
 - Members residing in an NF 1:125.
- Care coordination for members who participate in the self-directed CB:
 - CCL2 is 1:75; and
 - CCL3 is 1:50.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	-------------------------------------	--

MCOs or its delegate shall submit, upon request by HSD, a Care Coordination Staffing Plan, which at a minimum shall specify:

- The number of Care Coordinators, care coordination supervisors, other care coordination team members the MCO plans to employ;
- The ratio of Care Coordinators to members;
- The MCO’s plans to maintain ratios as outlined by care coordination level and the explanation of the methodology used for determining such ratios;
- How the MCO will ensure such ratios are sufficient to fulfill the Agreement requirements;
- The roles and responsibilities for each member of the care coordination team;
- A strategy that encourages the use of Native American Care Coordinators and limits duplication of services between Indian Health Services, Tribal Health Providers, and Urban Indian Providers (I/T/U) and non-I/T/U providers;
- 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
- How the MCO will use Care Coordinators to meet the needs of New Mexico’s unique population.

The MCO or its delegate shall ensure members have a telephone number for direct contact with their Care Coordinator and/or a member of their care coordination team, (without being routed through several contact points), during normal business hours (8:00 a.m. – 5:00 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 or its delegate’s care coordination unit. Calls requiring immediate attention shall be “warm” transferred directly to another Care Coordinator, not letting the call go to voice mail. After normal business hours, calls requiring immediate attention by Care Coordinator shall be handled by the member services line, as stipulated by Section 4.15.1 of the Agreement.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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When Native American members request a Native American Care Coordinator, the MCO must employ or contract with a Native American Care Coordinator or contract with a CHR to serve as the Care Coordinator.


The MCO or its delegate must accommodate the member’s requests to change to a different Care Coordinator if desired and if there is an alternative Care Coordinator available. Such availability may take into consideration the MCO’s or its delegate’s need to efficiently deliver care coordination in accordance with the requirements in the Agreement. In ensuring quality and continuity of care the MCO or its delegate shall make efforts to minimize the number of changes in a member’s Care Coordinator. The MCO or its delegate may need to initiate change in the following circumstances:

- Assigned Care Coordinator is no longer employed by the MCO or its delegate;
- There is a conflict of interest preventing neutral support for the member;
- Care Coordinator is on temporary leave from employment; or
- Caseload of the assigned Care Coordinator must be adjusted due to its size or intensity.

The MCO or its delegate shall develop policies and procedures regarding notice to members of Care Coordinator changes initiated by either the MCO or its delegate, or the member, including notice of planned Care Coordinator changes initiated by the MCO or its delegate.

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

Initial training shall be provided by the MCO or its delegate 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.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.9. 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 noncompliant with recommended BH 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.

The following protocol is to be utilized across MCOs, agency providers, and State employees and programs for each recipient identified as part of the HHR/HRU 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 all parties agree on appropriate responses in a non-compliant care situation. The State may partner with MCOs to make this intervention consistent for all MCOs and all individuals identified as HHR/HRU.


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

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 4: Care Coordination</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

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


When HHR/HRU recipients 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, the MCOs will utilize their complex case team and complex case rounds protocol.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.10. MCO Care Coordination with 1915(c) HCBS Waivers: DDs, MF, and MI VIA

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

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	-------------------------------------	--

4.11. Overview of Medicaid 1915(c) HCBS Waiver Program

- Developmental Disabilities Waiver (DDW) Program


The DDW provides an array of HCBS to help individuals with DDs to remain in their homes and communities as opposed to institutional care, become more independent, and reach their personal goals. The DDW serves individuals who meet an ICF-IID LOC. DDW individuals have a COE 096.

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

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

- Medically Fragile Waiver (MFW) Program

The MFW serves individuals who have been diagnosed with an MF condition defined as a life threatening, chronic condition which results in a prolonged dependency on skilled nursing care at home. MFW individuals have a COE 095. MFW recipients meet an ICF/IID LOC, as well as established MF parameters.

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	-------------------------------------	--

The MFW provides the following HCBS: RN case management; private duty nursing (RN, licensed practical nurse [LPN]); home health aide; behavior support consultation; respite care; nutritional counseling; skilled therapies (physical, occupational, and speech) for adults; and specialized medical equipment. MFW services are supplementary to EPSDT benefits for recipients under the age of 21.

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

- **Mi Via Self-Directed Waiver Program**

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

Mi Via provides the following services: consultant/support guide services; behavior support consultation; community direct support; customized community supports; in-home living supports; emergency response network; Employment Supports services; environmental modification services; Home Health Aide; homemaker/direct support services; nutritional counseling; personal plan facilitation; private duty nursing for adults; respite; skilled therapies for adults; specialized therapies; related goods; and non-medical transportation. Mi Via services are supplementary to EPSDT benefits for participants under the age of 21 years old.




Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.12. MCO Care Coordination Activities and the 1915(c) HCBS Waiver Service Plan (ISP or SSP)

The MCO Care Coordinator shall request a copy of the approved DDW LOC abstract (MAD 378 form) and CIA from the Medicaid TPA for the purpose of obtaining a complete, comprehensive picture of the recipient and their needs. A Client Information Update (CIU) form/MAD 054 is faxed to the TPA to request the LOC abstract and CIA. The Care Coordinator has no influence in regards to the DDW services and budget. The Care Coordinator cannot make recommendations or changes to the DDW ISP and Budget.

The MCO will not complete an NF LOC on members enrolled in the DD 1915(c) waiver. Utilize the DDW LOC and CIA information obtained from the Medicaid TPA to complete certain portions of the CNA prior to initiating a visit with the recipient/member.

Have knowledge that while the MCO is responsible for annual CNA visits, the DD waiver case manager assists the member with the DD waiver LOC assessment process and ISP and Budget development. Utilize only the PH and BH portion of the MCOs' CCP for members who are receiving HCBS through the DD waiver.

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




Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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


	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.13. MCO Care Coordination Activities for MF EPSDT (Non-Waiver) Members Case Managed by UNM/MFCMP

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

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

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

	Section 4: Care Coordination	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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4.14. Transitions from the Non-Medicaid Brain Injury Services Fund to a Centennial Care MCO

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

- The MCO shall maintain ongoing communication, enlist the involvement of, and coordinate with BISF service coordinators to effect the full transition of the member’s care from the BISF to the MCO. To effect the full transition of MCO members:
 - The HRA shall include questions about specific health diagnoses, including brain injury.
 - For members who identify as having brain injury during the HRA, opportunity shall be given to reschedule the HRA when natural supports and advocates, including a BISF service coordinator can be presented. During any HRA, information shall be requested by the reviewer about the member’s specific needs and what services were assessed as needed through the BISF or its currently contracted providers.
 - An HRA containing information about a self-reported brain injury shall trigger the scheduling of a CNA to include the person with the brain injury, any natural supports or advocates, and the BISF service coordinator or BISF life skills coach, as applicable.
 - All parties are to ensure a Release of Information has been signed by the member to affect the participation of the BISF service coordinator and/or other identified advocates in the member’s transition.
 - In the event a BISF participant was assigned to an MCO and wishes to transfer to a different MCO, the receiving MCO shall have the responsibility of working with the BISF service coordinator.
 - The MCO Care Coordinator is to acquire a copy of the BISF participant’s *Confirmation of ICD-10 code* and copies of any medical records entrusted to the BISF service coordinator to ensure their inclusion in the member’s file. These efforts are intended to



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

preserve the history of brain injury and ensure that care needs related to the brain injury diagnosis can be readily implemented.

- The MCO Care Coordinator shall maintain the primary responsibility for completing any transition paperwork but may request the assistance of the BISF service coordinator, as is mutually agreeable.
- The MCO Care Coordinator shall assume the responsibility of assisting the member in setting up the services identified on the member's CCP. The MCO Care Coordinator may consult with the BISF service coordinator regarding available service and community support providers.
- Any additional recommendations made by the BISF service coordinator shall be noted in the member's file.
- The MCO shall maintain continuity of care and implement the CCP services and supports that are needed to support the independent functioning of the member in their home and community.
- The MCO shall have the primary responsibility in assisting members who identify that they wish to self-direct their care. The input of the BISF service coordinator may be considered in anticipation of a SDCB budget and SSP to meet the member's anticipated needs.
- The MCO shall receive brain injury training by the HSD including: general brain injury information; available state and community resources; and communication strategies. Other topics may include: how to conduct assessments that capture the needs of brain injury; and how to develop a CCP that considers the needs of members with brain injury. Training by the MCO shall be required for any new care coordination staff within three months of employment, with renewed training to occur on a two-year schedule.



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

4.15. Appendix

4.15.1. Health Risk Assessment



Health Risk Assessment (HRA)

Member's Name (First, Middle, Last)		Member's Medicaid ID	Date
Has Member Given Permission for Another Person to Complete this form? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Person Completing/Assisting with the Completion of This Assessment and Their Relationship to Member	
Member's Address		City	State Zip
Home Phone	Cell Phone	Other Phone	
Emergency Contact Name/Phone			Date of Birth
Assessment Method <input type="checkbox"/> Telephonic <input type="checkbox"/> In-person <input type="checkbox"/> Other		Demographics Verified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Assessment Type <input type="checkbox"/> Initial assessment <input type="checkbox"/> Reassessment <input type="checkbox"/> Change in health status			

Question	Response
1. Do you have a language need other than English? Do you need translation services? Please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No _____
2. Do you have any special preferences we should be aware of?	<input type="checkbox"/> Cultural preference <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Religion/Spiritual needs or preferences <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Literacy <input type="checkbox"/> None <input type="checkbox"/> Other (describe): _____
3. What is your main health concern right now?	_____
4. Do you have any current or past physical and/or behavioral health conditions or diagnoses?	<input type="checkbox"/> Behavioral health diagnosis <input type="checkbox"/> Comorbid conditions <input type="checkbox"/> ICF/MR/DD <input type="checkbox"/> High risk pregnancy <input type="checkbox"/> Transplant patient <input type="checkbox"/> Medically Fragile Waiver Program <input type="checkbox"/> Medically frail <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Other acute or terminal disease: _____
5. (Adult only question) Compared to others your age, would you say your health is.....?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
6. Do you have any pending physical health procedures or behavioral health appointments? Date of most recent physical examination or medical appointment:	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
7. Have you visited the Emergency Room in the past 6 months? If yes, how many visits? Date(s) of ER visit(s): Reason for visit(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 or more _____ _____



Section 4: Care Coordination

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Question		Response
8.	Have you stayed overnight in the hospital in the past 6 months? If yes, how many times? If yes, were you readmitted within 30 days of discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 or more <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	How many medicines are you currently taking?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 6+
10.	What is your current living situation?	<input type="checkbox"/> Homeless <input type="checkbox"/> Living alone <input type="checkbox"/> Living in group home <input type="checkbox"/> Living in shelter <input type="checkbox"/> Living with other family <input type="checkbox"/> Living with others unrelated <input type="checkbox"/> Living with spouse <input type="checkbox"/> Living in assisted living facility <input type="checkbox"/> Lives in out of state facility <input type="checkbox"/> Lives in out of home placement <input type="checkbox"/> Dependent child in out of home placement <input type="checkbox"/> Living in a nursing facility <input type="checkbox"/> Other (describe): _____
11.	Do you need assistance with 2 or more of the following? Is your need for assistance being met today?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Dressing <input type="checkbox"/> Bathing/grooming <input type="checkbox"/> Eating <input type="checkbox"/> Meal acquisition/preparation <input type="checkbox"/> Transfer <input type="checkbox"/> Mobility <input type="checkbox"/> Toileting <input type="checkbox"/> Bowel/bladder <input type="checkbox"/> Daily medication <input type="checkbox"/> Other: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
12.	Do you need or are you interested in Long-Term Care services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	An advance directive is a form that lets your loved ones know your health care choices if you are too sick to make them yourself. Do you have a living will or an advance directive in place? Could I send you more information?	<input type="checkbox"/> Living will <input type="checkbox"/> Advance directive (for medical care) <input type="checkbox"/> Advance directive (for psychiatric care) <input type="checkbox"/> No living will or advance directive in place <input type="checkbox"/> Declined discussion <input type="checkbox"/> Requested further information
14.	Are you interested in receiving Care Coordination Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

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



Section 5: Transitions of Care

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

5. Transitions of Care

5.1. General Information


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

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

- Transition from an NF to the community;
- Transition for member(s) with special circumstances;
- Transition for member(s) moving from a higher LOC to a lower LOC;
- Transition for member(s) turning 21 years of age;
- Transition for member(s) changing MCOs while hospitalized;
- Transition for member(s) changing MCOs during major organ and tissue transplantation services;
- Transition for member(s) changing MCOs while receiving outpatient treatment for significant medical conditions;
- Transition for member(s) changing MCOs;
- Transition for member(s) previously in FFS;
- Transition for member(s) moving from a residential placement or institutional facility (including psychiatric hospitals) to a community placement;
- Transition for children returning home from a foster care placement;
- Transition for member(s) released from incarceration or detention facilities;
- Transition for member(s) discharging from a hospital;
- Transition for member(s) discharging from out-of-home placements (ARTC, RTC, Group Home, Therapeutic Foster Care [TFC]) and crisis centers related to BH treatment; and/or

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---------------------------------------	--

- Transition for member(s) who are preparing to receive out-of-state treatment.

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

5.2. Transitions of Care

The MCOs shall develop and implement methods for identifying and facilitating care coordination for all members involved in various transition scenarios. Such methods shall include, at a minimum:

- The CNA;
- Preadmission Screening and Resident Review (PASRR);
- MDS;
- Provider referrals to or from hospitals and RTCs;
- Ombudsman;
- Family member;
- Change in medical status;
- Member self-referral;
- Community Reintegration Allocation received;
- State Agency Referral; and/or
- Incarceration or detention facility referral.

If a member is a candidate for transitioning to the community, the Care Coordinator shall facilitate the development of and implementation of a transition plan which must be labeled “Transition of Care Plan” and may be a stand-alone document or included in the CCP. If included as a part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing. The transition of care plan shall remain in place for a minimum of 60 calendar days from the date of the decision to pursue transition or until the transition has occurred and a new CCP is in place. The transition of care plan shall address the member’s transitional needs including but not limited to:

- PH and BH needs;
- CB needs;

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

- Continuation of Medicaid eligibility;
- Selection of providers in the community;
- Housing needs;
- Financial needs;
- Interpersonal skills (the social skills people use to interact effectively with other people, including the ability to convey one’s needs); and
- Safety.

The Care Coordinator shall conduct an additional assessment within 75 calendar days after the transition to determine if the transition was successful and to identify any remaining needs resulting in a new CCP or modifications to an existing CCP.

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

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

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

5.3. Transitions of Care Requirements

The MCO shall establish policies and procedures to ensure all members are contacted in a timely manner and are appropriately assessed using HSD prescribed time frames, processes and tools, to identify needs.

The MCO shall coordinate with the discharge planning teams at hospitals and institutions (e.g., NFs, jails/prisons, juvenile detention centers, RTCs, psychiatric hospitals, behavioral health facilities) to address at a minimum:

- Need for HCBS;
- Follow up appointments;
- Therapies and treatments;
- Medications; and/or
- DME.

The MCO shall notify the assigned CYFD lead worker (permanency placement worker) for protective services involved children and youth and Juvenile Probation Worker for juvenile justice-involved youth within 30 business days prior to transition in care for CYFD-involved children/youth.

The MCO shall perform an in-home assessment for members who are transitioning from an inpatient hospital or NF stay within three calendar days after the transition. The assessment will address at a minimum:

- Safety in home environment;
- PH needs;
- BH needs;
- Housing needs;
- Continuation of Medicaid eligibility;
- Financial needs;

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

- CNA if one is not in place; and
- CB needs and services in place.

The MCO shall contact the member monthly for three months to ensure continuity of care has occurred and the member’s needs are met. The MCO shall not transition members to another provider for continuing services unless the current provider is not a contract provider. The MCO shall facilitate a seamless transition to new services and/or providers, without any disruption in services as outlined in the CCP.

For members who are preparing to receive out-of-state treatment, the MCO shall ensure daily updates are provided to the member and/or AR about the status of the out-of-state provider agreement and authorized treatment plan until treatment begins.

The MCO shall maintain active communication with the member and/or AR once out-of-state treatment begins, including weekends and holidays, for the duration of the treatment. The MCO shall resume care coordination activities pursuant to 4.4 of the Agreement following treatment completion and member’s return to New Mexico.

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

5.4. Transition of Care Requirements for Pregnant Women

In the event a member enrolling with an MCO is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment in the MCO, the MCO shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract provider) through the postpartum period, without any form of prior approval.

In the event a member enrolled with an MCO is in her first trimester of pregnancy and is receiving medically necessary covered prenatal care services prior to enrollment, the MCO shall be responsible for the costs related to the continuation of such medically necessary prenatal care services. This includes the delivery, without any form of prior approval and without regard to whether such services are being provided by a contract or non-contract provider. This coverage is required for up to 60 calendar days from the member’s enrollment or until the member may be reasonably transferred to a contract provider without disruption in care, whichever is less.

If the member is receiving services from a contract provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services from that provider, without any form of prior approval, through the postpartum period.

If the member is receiving services from a non-contract provider, the MCO shall be responsible for the costs of continuation of medically necessary covered prenatal services, without any form of prior approval, until such time as the MCO can reasonably transfer the member to a contract provider without impeding service delivery that might be harmful to the member’s health in accordance with Section 4.4.16.3 of the Agreement.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---------------------------------------	--

5.5. Transfer from the Health Insurance Exchange

The MCO must minimize disruption of care and ensure uninterrupted access to medically necessary services for individuals transitioning between Medicaid and qualified MCO coverage on the Health Insurance Exchange.

At a minimum, the MCO shall establish transition guidelines for the following individuals:

- Pregnant women;
- Individuals with significant health care needs or complex medical conditions;
- Individuals receiving ongoing services or who are hospitalized at the time of transition; and
- Individuals who received prior authorization for services from its qualified MCO.

The MCO is expected to coordinate services and provide phase-in and phase-out time periods for each of these individuals, and to maintain written policies, procedures, and documentation to address coverage transitions.

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

5.6. Transitions of Care for Members Moving from a Higher LOC to a Lower LOC

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 LOC. Transitions from inpatient and BH residential treatment facilities for both children and adults must be addressed. At a minimum, the following must be addressed:

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

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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5.7. Transitions of Members Turning 21 Years of Age

All members, including those who are under the care of EPSDT, must be transitioned to other services on their 21st birthday. The Care Coordinator must initiate a transition plan by the age of 20 years, which is ongoing until the member leaves the EPSDT program. The transition plan must be labeled “Transition of Care Plan” and may be a stand-alone document or included in the CCP. If included as part of the CCP, the “Transition of Care Plan” must be clearly labeled for MCO tracking and HSD auditing. The transition plan must:

- Establish a plan that is age appropriate and addresses the transition needs of the member:
 - Health condition management;
 - Developmental and functional independence;
 - Education;
 - Social and emotional health;
 - Guardianship; and
 - Transportation.
- Ensure members and, when authorized, family members, guardians and PCPs are part of the development and implementation of the transition plan.
- Document the transition plan in the medical record.
- Provide the member, and when authorized, family members and guardian with a copy of the transition plan.
- Establish a timeline for completing all services the member should receive through EPSDT prior to his or her 21st birthday.
- Review and update the plan and timeline with the member, and when authorized, the guardian and family prior to official transition to adult provider.
- Advise the member’s PCP of the discharge and ensure coordination of the services with the adult PCP.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 5: Transitions of Care</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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5.8. Transition for Members changing MCOs while Hospitalized

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

- 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.
- Notification to the hospital and attending physician of the transition by the relinquishing MCO. The relinquishing MCO must notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving MCO for authorization of continued services. If the relinquishing MCO fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing MCO will be responsible for coverage of services rendered to the hospitalized member for up to 30 calendar days. This includes, but is not limited to, elective surgeries for which the relinquishing MCO issued prior authorization.
- 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.
- 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 PCP, 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.

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

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

	<p>Section 5: Transitions of Care</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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5.9. Transition for Members Changing MCOs during Major Organ and Tissue Transplantation Services

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

If a member changes to a different MCO while undergoing transplantation at a transplant center that is not a contracted provider, each MCO is responsible for its respective dates of service (DOS). 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.

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---------------------------------------	--

5.10. Transition for Members Changing MCOs while receiving Outpatient Treatment for Significant Medical Conditions

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

	Section 5: Transitions of Care	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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5.11. MCO Requirements for Members Transitioning between MCOs

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

- The relinquishing MCO must provide relevant information regarding members who transition to a receiving MCO.
- The MCO must also provide protocols for the transfer of pertinent medical records, as discussed in this policy, and the timely notification of members, subcontractors, or other providers, as appropriate during times of transition.
- The receiving MCO must provide new members with their handbook and emergency numbers within 10 calendar days of transition for acute care members and within 12 calendar days of transition for all other 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 ensure 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.
- The relinquishing MCO that fails to notify the receiving MCO of transitioning members with special circumstances, or fails to send the transition notification, will be responsible for covering the member's care resulting from the lack of notification, for up to 30 calendar days.
- The MCO shall ensure that any member entering the MCO has access to services consistent with the access they previously had and is permitted to retain their current provider for a period of time, if that provider is not contracted with the MCO.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6. Nursing Facilities

6.1. General Information

This policy establishes guidelines for the MCOs regarding NFs. The NF LOC Criteria and instructions can be found on the HSD website.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.2. NF Procedures for Requests for Prior Approval

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



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.3. Pre-Admission Screening and Resident Review (PASRR)

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

- Purpose of PASRR is as follows:
 - To determine whether a resident requires a specific level of nursing care;
 - To determine if there is suspicion of serious mental illness (SMI) or intellectual disability/related condition (ID/RC);
 - To assess persons suspected of having serious SMI or ID/RC;
 - To assess whether specialized services for SMI or ID/RC are needed; and,
 - To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program for those with SMI or ID/RC.
- Organization of the PASRR: PASRR is divided into two levels: Level I Screen and Level II Evaluation.
 - Level I Screen: A Level I Screen must be completed prior to admission on every NF applicant. If, during the Level I Screen, it is determined that the individual is suspected of having either SMI or ID/RC, a Level II Evaluation or PASRR waiver must occur prior to admission. A Level I Screen must also be done if there has been a significant change in the physical or mental condition of a resident who is suspected of having, or previously determined to have SMI or ID/RC. “Significant change” for PASRR purposes can be tied to the already existing regulatory definition for significant change that prompts an alteration in a resident’s MDS. Significant change referrals must be made to the PASRR Unit no later than 21 business days after the occurrence of the significant change. The PASRR Unit is required to review the completed Level I Screen packet within seven to nine business days of receipt of the completed packet from the NF. Notification of the review decision must be submitted to the NF by phone or in writing within that time period.
 - Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having SMI or ID/RC, a Level II Evaluation or a PASRR waiver must be



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

completed prior to the admission of the resident. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident.

- PASRR Waiver:
 - If an individual falls within one of the following categories, a complete Level II Evaluation may not be performed. A PASRR Waiver is granted on a case-by-case basis.
 - The resident has a primary diagnosis of dementia.
 - The resident is being discharged from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed 30 business days.
 - The resident is suspected of having SMI or ID/RC but is certified to be terminally ill with a life expectancy of six months or less and is in need of continuous nursing care and/or medical supervision and treatment due to a physical condition.
 - The severity of the resident's medical condition and medical treatment needs are so extensive that specialized SMI or ID/RC services are not likely to be beneficial.
 - The resident who is suspected of having SMI or ID/RC and is admitted directly to an NF from a home for very brief and finite stay (up to 14 days) for the purpose of providing respite to in-home caregivers.
 - If APS directly admits an individual to an NF because the individual is in harm's way, the PASRR Unit is required to complete the Level II assessment within 10 business days.
- Level I Screen Process
 - An NF is required to submit copies of the Level I Screen for each resident with the MDS to the MCO/Utilization Review (UR) Contractor. The Screen and other necessary documentation must be sent with the MDS to avoid delays in the review process.
 - The MCO/UR Contractor logs in the date on the recipient screen when the MDS, Level I Screen, and other documentation is received.
 - The MCO/UR Contractor scans the Level I Screen. If the resident passes the Screen, the MCO/UR Contractor determines the NF LOC. If the resident fails the Screen, no



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

further NF LOC action is to be taken by the MCO/UR Contractor. The MDS Screen, and other documentation, must be submitted to the PASRR Unit for a Level II determination.

- The MCO/UR Contractor then sends a notice to the NF that the MDS and other documentation have been sent to the PASRR Unit for a Level II Evaluation determination.
- Level II Evaluation Process: There are two types of Level II PASRR reviews.
 - SMI PASRR II screens are completed by the BHSD contractor for residents living in an NF or individuals being admitted from a hospital or home to an NF.
 - The PASRR Unit sends the documents to the BHSD contractor to complete an evaluation and makes the Level II determination on the review portion of the MDS and the NF LOC determination, then returns to the PASRR Unit. The PASRR Unit sends the NF LOC determination and MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation with the NF LOC determination if a waiver was not granted.
 - Within 24 hours of the MCO/UR Contractor receiving the NF LOC determination from the NF determined by the BHSD contractor, the MCO/UR Contractor transmits the NF LOC determination via the appropriate interface file.
 - If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews follow the process above by the PASRR Unit instead of the MCO/UR Contractor.
 - If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for an NF LOC determination.
 - ID and RC PASRR II screens are completed by the PASRR Unit for residents living in an NF or individuals being admitted from a hospital or from home to an NF.
 - The PASRR Unit completes an evaluation and makes the Level II determination on the review portion of the MDS and returns the MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation for an NF LOC determination if a waiver was not granted.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- All subsequent PASRR Level II reviews are performed by the PASRR Unit unless waived by the PASRR Unit.
- All subsequent NF LOC determinations are made by the MCO/UR contractor.
- PASRR and re-admission from a hospital: The NF contacts the PASRR Unit if the hospitalization of a resident results in a change in the Level I Screen. If an individual is hospitalized from the NF, the hospital will complete a new Level I screen prior to discharge.
- PASRR and Medicaid eligibility pending: If a resident is in a “Pending Medicaid” status at the time of MDS submission and the resident fails the Level I Screen, the MDS is forwarded to the PASRR Unit as notification while the following actions occur:
 - The NF LOC determination is made by the MCO/UR Contractor.
 - The MCO/UR Contractor transmits the NF LOC determination via the appropriate interface within 24 hours of making the NF LOC determination. The information is processed by the appropriate Income Support Division (ISD) office once received. The MCO also sends the NF notification form to the NF with the NF LOC effective dates and prior authorization information.
 - Once eligibility is established, the ISD office notifies the NF and the MCO.
 - The NF must notify the PASRR Unit of the status of the resident’s eligibility.
 - The MDS, which includes the Medicaid number and the certified length of stay, is completed by the PASRR Unit.
 - Upon completion, the MDS is submitted to the MCO/UR Contractor.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.4. Level of Care Packet for Nursing Facilities

- PASRR
- NF LOC Notification Form - used for all prior approval reviews
 - All requests for prior approval will be submitted on the NF LOC Notification Form.
 - The NF should document what type of review is being requested at the top of the NF LOC Notification Form:
 - Initial;
 - Continued Stay;
 - Medicaid Pending;
 - Transfer;
 - Re-admit;
 - Reconsideration; and/or
 - All other required fields must be completed.
- MDS
 - An MDS and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.
 - All locator fields must be clearly marked on the MDS.
 - When the resident goes from Medicare co-pay to Medicaid, the NF submits an Internal MDS that begins the UR process for the resident.
 - Appropriate documentation must accompany the MDS. Generally, appropriate documentation includes a valid order and must:
 - Be signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant;
 - Be dated; and
 - Indicate the LOC – either high NF (HNF) or low NF (LNF).



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

The NF must submit the initial NF LOC packet to the MCO no later than 30 calendar days after admission, which includes all of the above documentation and the physician's order. The MCO may assign unexcused late days if the NF submits the LOC packet later than 30 calendar days. Please refer to the Current/Retrospective Reviews Section above for more information about assignment of late days.

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 an RN or LPN who must also sign and date the order. It must be clearly indicated 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 NF LOC Instructions and Criteria within five business days of receiving a completed packet. The MCO shall review the documentation provided to determine the appropriate NF LOC and transmits the determination via the appropriate interface file within 24 hours of making the NF LOC determination. 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, an RFI sheet will be generated by the MCO and sent to the NF. If the required documentation is not provided to the MCO within 14 business days of the request, it will be technically denied. The MCO will make three attempts during the 14 business day period to contact the NF to obtain the information. The MCO will transmit a technical denial via the ASPEN interface file within 24 hours of no response from the NF. Please see Current/Retrospective Reviews for more information on assignment of late days.

Note: A formal RFI to the NF to justify the HNF request is not required when reviewing and processing HNF requests that clearly do not meet HNF criteria but do meet LNF criteria or vice versa. In the event a determination is upgraded or downgraded from the physician's order the MCO shall assign the LOC and provide the NF with technical assistance to educate the NF on determination criteria.

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



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

For short-term stays (90 days or less) the MCO will provide ISD with NF LOC determination dates but will only issue a prior authorization to the NF for the authorized bed days, if appropriate and after eligibility has been established.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.5. Denial of Requests for Prior Approval

If the NF LOC criteria is not met and the request for initial NF placement or Medicaid pending is denied, the MCO will send the referring party and the applicant a denial letter within five business days of a completed packet, with the reason for denial as determined by the provider. The requesting provider may request a reconsideration to the MCO. If no reconsideration is requested, the MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. The applicant will receive a Notice of Case Action from the ISD office, which explains the right to request an administrative hearing.

If the NF LOC criteria is not met for an existing resident, the MCO will send the referring NF and the member a denial letter with information regarding the right to appeal to the MCO before requesting an administrative hearing. The MCO will not transmit the denial via the ASPEN until a final appeal decision has been made or until after the allowed time to request an appeal has lapsed, whichever is later.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.6. Reserve Bed Days

Medicaid pays to hold or reserve a bed for a resident in an NF 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.

- Medicaid covers six reserve bed days per calendar year for every LTC resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval.
- Medicaid covers an additional six reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan.
 - Resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.
 - 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.

Requests for additional discharge reserve bed days must be submitted by the NF to the MCO that the resident is enrolled with for prior approval. 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.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.7. Initial Determination, Redetermination, and Pending Medicaid Eligibility

- **Initial Determination:** All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the NF Procedures for Requests for Prior Approval Section above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission.
- **Redetermination:** The medical documentation must be faxed and received by the MCO a minimum of 60 calendar days prior to the start date of the new certification period for LNF and 30 calendar days prior for HNF.
- **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. Note: A resident on SSI is not considered Medicaid Pending.
 - When an individual is admitted to an 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.
 - The MCO will review the information submitted and determine the NF LOC.
- The Prior Authorization form will be completed by the MCO and sent to the NF.
- The MCO will transmit the NF LOC determination via the ASPEN interface within 24 hours of making the determination.



6.8. Care Plan and Emergency Preparedness

Care Plan

The NF must develop a care plan, per 42 CFR 483.21, for each resident within 48 hours of admission, to include instructions needed to provide effective and person-centered care that meets professional standards of quality of care. The care plan must include all specialized or rehabilitation services the NF will provide as a result of PASRR recommendations.

Emergency Preparedness

The NF must be in compliance with 42 CFR 483.73 including, but not limited to:

- Self-Assessment and Planning:
 - Develop an emergency plan based on a risk assessment;
 - Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities; and
 - Update emergency plan at least annually.
- Policies and Procedures:
 - Develop and implement policies and procedures based on the emergency plan and risk assessment;
 - Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency; and
 - Review and update policies and procedures at least annually.
- Communication Plan
 - Develop a communication plan that complies with both Federal and State laws;
 - Coordinate patient care within the facility, across health care providers, and with State and local public health departments and emergency management systems;
 - Review and update plan annually; and



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Share information from the emergency plan with residents, family members or representatives, and the member's MCO.
- Training and Testing Requirements
 - Develop and maintain training and testing programs, including initial training in policies and procedures;
 - Demonstrate knowledge of emergency procedures and provide training at least annually; and
 - Conduct drills and exercises to test the emergency plan.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.9. Retroactive Medicaid Eligibility

Written requests for prior approval based on a resident's retroactive financial eligibility must be reviewed by the MCO within 30 calendar days of the date of the eligibility determination. The NF must submit all appropriate medical documentation to the MCO for the NF LOC determination. The MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. Requests for retroactive eligibility will not be accepted after 180 days of the Medicaid eligibility determination date. Please see NMAC 8.281.600.13.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.10. Re-Admission Reviews

When the resident leaves the NF for three or more midnights for an inpatient hospital stay, a readmission review is required.

The NF must submit a re-admit MCO approval request form within 30 calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF.

- When the resident is re-admitted to the NF and has more than 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.
- If the resident has less than 30 calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit a re-determination (annual or continued stay) request on the notification form along with supporting documentation.



6.11. Current/Retrospective Reviews

Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the NF.

A request for a current or a retrospective review for initial (including Medicaid pending), redetermination or re-admit reviews will be considered; however, the below outlines the procedure for unexcused and excused assignment of late days by the MCO.

Unexcused late reviews

Starting July 1, 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 to the MCO with a detailed written explanation and documentation that supports the request for an excusable late review. Reimbursement and retrospective reviews:

- 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.
- Medicaid will not reimburse NFs for DOS not covered by the MCO prior authorization form. In addition, the Medicaid member and his/her family member(s) cannot be billed for the services provided by the NF. The NF will not discharge the resident due to assignment of late days by the MCO.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.12. Transfer from Another NF

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

- 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.
 - If there are more than 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.
 - If there are less than 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.
- 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.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.13. Changes in the LOC

All changes in LOC require a new notification form that should be submitted within 30 calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write “LOC 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 NF LOC Instructions and Criteria). The date the LOC change occurred must be clearly stated.



6.14. Discharge Status

Discharge status occurs when a resident no longer meets the LOC that qualifies for NF placement, but there is no option for community placement at that time. Individuals are often already residing in an NF at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in an NF may clinically improve to the point that they no longer meet an NF LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the NF. 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 NF. 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 LNF level of reimbursement while the NF and the MCO actively address the development of community placement 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 the resident is being discharged from the facility. Families and residents should not be told the resident is being discharged from the facility. The MCO Care Coordinator, family, resident, and NF will work together to develop a transition plan to safely transition the resident to an alternate SOC per Section 5 of this Manual.

- Initial Discharge Status is authorized at LNF for a maximum of 90 calendar days, based upon the MCO physician determination.
- Continued Stay Discharge Status is authorized at LNF for not less than 180 calendar days and up to 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 an NF 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.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.15. Reconsideration, Appeal, Administrative Hearing

- Reconsideration: Providers who disagree with an NF LOC determination can request reconsideration. Members who disagree with an 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 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 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.
- The request for reconsideration must include the following:
 - Statement that reconsideration is requested;
 - Reference to the challenged decision or action;
 - Basis for the challenge;
 - Copies of any document(s) pertinent to the challenged decision or action; and
 - Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision.
- Appeal: If a reconsideration determination is adverse to the member, the member may request an appeal with his or her MCO in accordance with 8.308.15 NMAC.
- HSD Administrative Hearings: After the member has exhausted the MCO appeals process, the member may request an HSD administrative hearing in accordance with 8.352.2 NMAC.
- State Administrative Hearing: After the parties have exhausted the MCO appeals process, the parties may request an administrative hearing according to State administrative rule 8.352.2 NMAC. The MCO/UR Contractor is responsible for the development of the Summary of Evidence (SOE) to ISD and for the testimony of the NF LOC denial during the fair hearing, including denied NF LOCs for Medicaid Pending residents.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.16. Communication Forms

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



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.17. External Audits of NF LOC Determinations

HSD or its designee will audit a sample of each MCO's NF LOC determinations to ensure the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of NF LOC determinations to HSD or its designee for review. HSD or its designee will meet with the MCO to discuss audit findings.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.18. MCO Internal Audits of NF LOC Determinations

Each MCO will conduct internal random sample audits of both facility and CB NF LOC determinations based on HSD NF LOC instructions and tool guidelines each quarter. The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HSD by the 7th day of the month following the end of the quarter along with any Quality Performance Improvement Plan via DMZ (NF LOC reviews folder). The naming convention for the results and findings file is MCO, quarter, year, internal audit results. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCO-name.Q1.18.internal audit results."



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

6.19. Appendices

6.19.1. NF LOC Communication Form

6.19.2. NF LOC Notification Form

6.19.1. NF LOC Communication Form



NF LOC Communication Form

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

I. Requestor Information

Date of Request	Click here to enter a date.		
FROM	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.
TO	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.

II. Communication:

NF Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN	xxx – xx – Click here to enter text.

a. Request for Information

<p>Request for following selected information:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Missing Member Demographics <input type="checkbox"/> Missing MDS Required fields: Click here to enter text. <input type="checkbox"/> MDS not within the service time frame requested <input type="checkbox"/> Need a valid physician order for: Click here to enter text. <input type="checkbox"/> Need member's Level I PASRR <input type="checkbox"/> Need member's Level II PASRR <input type="checkbox"/> Need current H&P <input type="checkbox"/> Need current signed and dated physician progress notes <input type="checkbox"/> Medicare COB if applying therapy as HNF criteria for dual member <input type="checkbox"/> Other: Click here to enter text.
--

b. Member Status Update

<p>Request for following selected member status update:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Discharge Status <input type="checkbox"/> Member Representative Info <input type="checkbox"/> Current Progress Note <input type="checkbox"/> Other: Click here to enter text.
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Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

c. Member MCO Update

Request for following selected member MCO update:

- Member current MCO selection: [Click here to enter text.](#)
- Member previous MCO assignment: [Click here to enter text.](#)

6.19.2. NF LOC Notification Form



NF LOC

Notification Form

I. Nursing Facility Prior Authorization Request

Nursing Facility Information:			
Date of Request	Click here to enter a date.	Type of Request	Click here to enter text.
Nursing Facility Name	Click here to enter text.		
NF Contact Name	Click here to enter text.		
Nursing Facility Fax	Click here to enter text.	Nursing Facility Phone	Click here to enter text.
Nursing Facility Email	Click here to enter text.		

Nursing Facility Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN#	xxx – xx – Click here to enter text.
Medicaid ID Number	Click here to enter text.		
NF Admission Date	Click here to enter a date.	Selected MCO	Click here to enter text.
Resident Rep Name	Click here to enter text.	Rep Phone	Click here to enter text.
Resident Rep Address	Click here to enter text.		

Requesting Service:			
NFLOC Type	Click here to enter text.		
Service Begin Date	Click here to enter a date.	Service End Date	Click here to enter a date.



Section 6: Nursing Facilities

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Documentation Requirements:

Initial Request:

- MDS
- Physician Order
- PASRR Level I and PASRR Level II if indicated by PASRR Level I
- History & Physical

Continuation Stay:

- Most recent MDS
- Physician Order
- Physician Progress Notes
- History & Physical

II. Utilization Management (For MCO Use Only)

Review Information:

Date of Review	Click here to enter a date.	Authorization Number	Click here to enter text.
NFLOC Begin Date	Click here to enter a date.	NFLOC End Date	Click here to enter a date.
Approved Bed Begin Date	Click here to enter a date.	Approved Bed End Date	Click here to enter a date.

LNF Factors:

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

HNF Factors:

- Oxygen
- Orientation / Behavior
- Medication Administration
- Interdisciplinary Progress Notes & Care Plans
- Rehabilitation Therapy
- Skilled Nursing
- Feeding
- Mobility / Transfer
- Other Clinical Factors

Approved NFLOC Type: [Click here to enter text.](#)

Comments: [Click here to enter text.](#)

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7. Community Benefits

7.1. General Information

CBs are services that provide assistance to individuals who require LTSS so they may remain in the family residence, in their own home, or in community residences. This program serves as an alternative to placement in a NF. CB do not provide 24-hour care and are intended as a supplement to an individual’s natural supports. CB services are available to members meeting a NF LOC. The member’s MCO shall provide the CB services as determined appropriate by the CNA. Members eligible for CBs have the option of selecting either the Agency-Based Community Benefit (ABCB) or SDCB.

Two eligibility components must be met prior to receiving CB services: financial eligibility, determined by the HSD/ISD and medical eligibility, determined by an MCO through an NF LOC assessment conducted as part of the CNA.

Members who have a Full Medicaid COE may be eligible for CB if they meet an NF LOC and indicate they have a need for CB. These individuals should request a CNA from their MCO to be assessed for CB. These individuals do not need an allocation to access CB (see Section 5 Transitions of Care). Individuals up to age 21 may be eligible for the EPSDT program, which provides personal care services (PCS). If a Medicaid enrolled minor indicates he or she has a need for CB and meets an NF LOC, an allocation is not needed to access CB services.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.2. Definitions

1. **Active Registration:** A registration is active if there is an open category of registration on the Central Registry.
2. **Activity of Daily Living (ADL):** Tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting and transferring.
3. **Agency Based Community Benefits (ABCB):** The CB services offered through a provider agency to a member who does not wish to self-direct his or her CB services.
4. **Allocation:** The opportunity given to a registrant who is NOME to apply for CBs.
5. **Allocation Packet:** The documents sent by HSD/MAD/LTSSB to a registrant that includes the Letter of Interest (LOI), Primary Freedom of Choice (PFOC), Withdrawal Form, Medicaid Application for Assistance, and a self-addressed stamped envelope.
6. **Central Registry:** A database that maintains a list of individuals who are interested in receiving CBs and may be eligible for an allocation.
7. **Community Benefits (CB):** HCBS that provide LTSS to eligible members that allow them to remain in the family residence, in their own home, or in community residences such as an Assisted Living Facility.
8. **HSD 100:** “Medicaid Application for Assistance” that is used to apply for CBs and is available online or at a local HSD/ISD office.
9. **Inactive Registration:** A registration is inactivated/closed under certain circumstances (see Section 7.10 of this Manual, Closing/Inactivating an Allocation).
10. **Letter of Interest (LOI):** The letter that is sent to a registrant informing him or her that an allocation is available and that he or she may apply for CBs.
11. **Notice of Allocation (NOA):** The letter that is sent to a registrant informing him or her that the PFOC was received at HSD/MAD/LTSSB and informs him or her of the next steps in the allocation process. The date of the NOA is the allocation date.
12. **Nursing Facility Level of Care (NF LOC):** The member's functional level is such that two or more ADLs cannot be accomplished without consistent, ongoing, daily provision, of some

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 7: Community Benefits</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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or all of the following levels of service: skilled, intermediate or assistance. A member must meet an NF LOC to be eligible for CB services.

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

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

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

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.3. Nursing Facility Level of Care

NF LOC determinations for CB members:

All individuals receiving CB services must meet NF LOC eligibility requirements initially and annually thereafter, unless eligible for continuous NF LOC.

Members who have a full Medicaid COE do not need an allocation to access CB. The member must contact his/her MCO Care Coordinator to request an NF LOC evaluation to determine if medical eligibility can be established. The Care Coordinator must schedule a CNA, to be completed in the member’s home. The CNA must be scheduled within 30 calendar days of the member’s request for CB services.

Once medical eligibility is established, the member must be reevaluated for NF LOC eligibility annually. The MCO Care Coordinator must begin the NF LOC evaluation process (i.e., schedule the CNA) 120 calendar days prior to the existing NF LOC expiration date. The MCO must send 120 and 60 calendar day reminder letters to the member. If the member has not complied with the CNA process and there are only 30 calendar days left before the NF LOC expiration date, the MCO will send a Notice of Action to the member explaining that CB services will expire in 30 calendar days due to member not complying with the NF LOC evaluation process. The NOA must advise the member that if CB services are desired, the CNA process must be completed. The notice must include member appeal and fair hearing rights.

Individuals requesting CB services who are not eligible for a full Medicaid COE, must place their name on the Central Registry as described later in this section of the Manual.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 7: Community Benefits</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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7.4. Continuous NF LOC for Certain Eligible Members

CB members who meet the following criteria may be eligible for a continuous NF LOC. The MCO is required to complete the CNA as outlined in Section 4 of the Manual.

- The member must have had an approved NF LOC for the prior three years.
- The approved NF LOC must be related to the member’s primary diagnosis.
- A continuous NF LOC status must be approved annually by the MCO Medical Director and documented in the member’s file.
- The member’s PCP must annually complete and sign a form that documents the member’s ongoing ADL deficits related to the member’s primary diagnosis. The MCO must maintain this form in the member’s file.
- The MCOs will be required to regularly report to HSD the number of members with approved continuing NF LOC status and other related information.

Conditions that may warrant a continuous NF LOC include, but are not limited to:

- Cerebral Palsy;
- Chronic Obstructive Pulmonary Disease (end stage);
- Cystic Fibrosis;
- Dementias (such as Alzheimer’s, Multi-Infarct, Lewy Body);
- Developmental Disability (such as microcephaly and severe chromosomal abnormalities);
- Neurodegenerative Diseases (such as ALS, muscular dystrophy, multiple sclerosis,);
- Paralysis secondary to Cerebral Vascular Accident;
- Parkinson’s Disease;
- Paraplegia;
- Quadriplegia;
- Spina Bifida;



Section 7: Community Benefits

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Paralysis secondary to severe spinal cord injury; or
- Ventilator Dependent.

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.5. External Audits of NF LOC Determinations

HSD or its designee will audit a sample of each MCO’s NF LOC determinations to ensure the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of NF LOC determinations to HSD or its designee for review. HSD or its designee will meet with the MCO to discuss audit findings.

	<p>Section 7: Community Benefits</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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7.6. MCO Internal Audits of NF LOC Determinations

Each MCO will conduct internal random sample audits of both facility and CB NF LOC determinations based on HSD NF LOC instructions and tool guidelines each quarter. The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HSD by the 7th day of the month following the end of the quarter along with any Quality Performance Improvement Plan via DMZ (NF LOC reviews folder). The naming convention for the results and findings file is MCO, quarter, year, internal audit results. For example, if the MCO is submitting first quarter reviews, the file shall be named “MCO-name.Q1.18.internal audit results.”

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.7. Registration for the CB for NOME Members

The ALTSD/ADRC (referred to as ADRC from this point forward) manages the Centennial Care Central Registry by enrolling individuals, completing the pre-assessment, assigning the category of registration, and sending Exception requests to HSD/MAD/LTSSB. Any individual has the right to place his or her name on the Central Registry if: it has been determined the individual is not currently Medicaid eligible, or current Medicaid shows a termination date, or the individual has applied for Medicaid and received a denial.

At the time of registration, if the individual has a Medicaid COE entitling the individual to full Medicaid benefits, the ADRC shall refer the individual to his or her MCO.

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

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

- **Community Reintegration** – provides individuals the opportunity to move out of an NF and back into the community for a registrant who is residing in an NF at the time of registration. In order to be eligible for CRI, the registrant must have resided in an NF for 90 consecutive days. Within the 90 consecutive days, the registrant may have been hospitalized and returned to the NF for the remainder of the 90 days. The individual participating in the community reintegration process must be capable of comprehending the decisions being made or have a primary caregiver or legal guardian that understands the options. The individual must not require ABCB services 24 hours per day in his or her home. The intent of

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	--------------------------------------	--

CRI is to assist the individual to become integrated into his/her community and be as independent as possible. The MCO must be able to ensure a reasonable level of health and safety for the member while ABCB services are being provided. ABCB services must be cost-effective and must not exceed the average annual per capita costs of NF services as determined by HSD.

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

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

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

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



Section 7: Community Benefits

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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

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

- To ensure continuity of care, an individual was receiving CBs under a full Medicaid category of assistance and his or her full Medicaid eligibility terminated. An individual must inform the ADRC that he or she has lost full Medicaid and was receiving CBs. The request must be made to ADRC within six months of termination of the full Medicaid category of assistance;
- An individual who was in an NF for 90 consecutive calendar days and was not registered for a CRI allocation prior to discharge. The request must be made to ADRC within 30 calendar days after discharge from the NF;
- An individual is residing in a Medicaid approved Assisted Living Facility, has been paying out of pocket, and can no longer afford the private pay;
- An individual who has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or Aids-Related Complex (ARC);
- An individual who no longer qualifies for the MFW and is ventilator dependent; or
- In rare cases, an individual with an extreme health and safety risk.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 7: Community Benefits</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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7.8. Allocation Process

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

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

When the HSD/MAD Director determines a regular allocation should be released, the allocation process begins by sending the Allocation Packet to the registrant. The registrant is notified there is an allocation available and is asked to respond by returning a completed PFOC and HSD 100, or a Withdrawal Form.

The Allocation Packet is stamped with “Allocation Packet” and contains the:

- LOI;
- PFOC;
- Withdrawal Form;
- HSD 100 “Medicaid Application for Assistance”;
- CBs Informational Brochure; and
- Self-addressed stamped envelope addressed to HSD/MAD/LTSSB.

Timeframes for the Allocation Packet:

- The registrant has 45 calendar days to return either a completed PFOC and HSD 100, or a Withdrawal Form to HSD/MAD/LTSSB.
- The registrant may request a one-time extension to return the PFOC and HSD 100, or Withdrawal Form by contacting the HSD/MAD/LTSSB, and if requested, it shall be granted



Section 7: Community Benefits

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

for up to 30 calendar days. Any additional time (extensions) requested by the registrant must be made directly to HSD/MAD/LTSSB for approval.

- If there is no response to the Allocation Packet either after the original 45 calendar days or after the expiration of any granted extensions, HSD/MAD/LTSSB shall send a closure letter to the registrant's mailing address on file.

Processing PFOCs:

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

- If the PFOC is not complete and/or signed, the PFOC will be returned to the registrant, identifying the information required, and providing the registrant up to 30 calendar days to complete and return the form. Failure to return the PFOC within the 30 calendar day time period will result in closure upon the 45th day, as described herein.
- If the PFOC **and** HSD 100 are completed and signed, HSD/MAD/LTSSB will process them by sending:
 - An NOA letter to the registrant with a copy of the PFOC, for their records;
 - A copy of the NOA, PFOC, and HSD 100 to the HSD/ISD Eligibility system; and
 - A copy of the NOA and PFOC to the registrant's MCO.

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.9. Eligibility

Once the PFOC and HSD 100 have been distributed to HSD/ISD and the MCO, HSD/MAD/LTSSB's "Processing PFOCs" is complete. HSD/MAD/LTSSB is unable to assist with medical or financial eligibility. Registrants must meet two types of eligibility, initially and annually, to receive and continue receiving CBs:

- **Medical Eligibility:** The medical eligibility determination is completed by the MCO. In order to be medically eligible, the registrant must meet an NF LOC. In addition, the CNA must indicate that the registrant has a need for CBs.
 - The NF LOC shall be determined and transmitted to ASPEN within 40 calendar days from the MCO's receipt of the PFOC.
 - The MCO shall submit the NF LOC determination to HSD/ISD, via the interface file, within 5 business days of the NF LOC determination so it can be used by HSD/ISD to complete the eligibility process.
 - If there is an existing NF LOC determination, the MCO shall submit the NF LOC effective dates to HSD/ISD, via the interface file, within 5 business days of the MCO's receipt of the PFOC so it can be used by HSD/ISD to complete the eligibility process. A new NF LOC does not need to be determined by the MCO, unless there are less than 120 calendar days remaining on the existing NF LOC.
 - The MCO shall submit the NF LOC effective dates and applicable SOC of ADB (Agency Directed Services) to the Omnicaid system, via the interface file, within 5 business days of receiving the member's initial enrollment on the Enrollment Roster file.
- **Financial Eligibility:** In order to be financially eligible, income and assets must be below the Institutional Care Medicaid (ICM)/Waiver maximum allowable amount. In addition, all other financial and non-financial eligibility requirements must be met as determined by HSD/ISD.

Once eligibility is approved by HSD/ISD, the registrant's ABCB services will be provided based on the CNA conducted by the member's MCO.

The member must participate in the ABCB service delivery model for a minimum of 120 calendar days before the member requests a switch to the SDCB service delivery model. A member must

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	--------------------------------------	--

contact their MCO Care Coordinator to discuss the switch from ABCB to SDCB. The CB services are described in Sections 8 and 9 of the Manual.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.10. Closing/Inactivating an Allocation

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

- The registrant returns a signed Withdrawal Form;
- The registrant does not return the PFOC within the required timeframes;
- The ADRC or HSD/MAD/LTSSB is informed the registrant intends to remain in the NF;
- The ADRC or HSD/MAD/LTSSB is informed the registrant is no longer a resident of the State of New Mexico;
- The ADRC or HSD/MAD/LTSSB has been notified the registrant has expired;
- The Allocation Packet is returned as undeliverable and no other contact information is available; or
- The registrant has a full Medicaid category of eligibility (COE) and has access to CB services through their MCO.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.11. Registrant Notice Requirements

The registrant is notified by letter in the following circumstances:

- New registration (mailed by the ADRC);
- When the State is unable to contact the registrant by telephone;
- When an allocation becomes available for the registrant (Allocation Packet);
- When an allocation is complete (NOA);
- When a registration is closed/inactivated for any reason other than a completed allocation;
and
- When the State has been notified that the registrant is deceased, a letter will not be sent to the registrant or the registrant's representative.

	Section 7: Community Benefits	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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7.12. Undeliverable Notice

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

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8. Agency-Based Community Benefits

8.1. General Information

The ABCB is intended to provide a community-based alternative to institutional care. Members selecting the Agency-Based model have the choice of the consumer delegated or consumer directed models for PCS.

HCBS shall meet the following standards:

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

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.2. Definitions

1. **Adult:** Individuals who are 21 years of age or older.
2. **Allocation:** Funding becomes available to serve additional individuals on the 1115 waiver who are NOME.
3. **Annual:** The 12-month period covered by a Care Plan, except where otherwise stated.
4. **Adult Protective Services Division (APS):** APS Division of the Aging and Long-Term Services Department.
5. **Care Coordinator (CC):** The individual responsible for coordinating a member's services in the managed care program.
6. **Child:** An individual under 21 years of age.
7. **Community Re-integration:** Provides individuals the opportunity to move out of a SNF into a community placement, after a 90-day continuous stay.
8. **Electronic Visit Verification (EVV):** EVV is a computer-based system that electronically verifies the occurrence of authorized personal care service visits by electronically documenting the precise time and location where a service delivery visit begins and ends.
9. **Face-to-Face:** Being in the physical presence of the individual who is receiving services.
10. **Human Services Department (HSD):** Designated by CMS as the Medicaid administering agency in New Mexico. HSD is also responsible for operating the ABCB Services for populations that meet the NF LOC (Disabled & Elderly, Brain Injury, and AIDS).
11. **Interdisciplinary Team (IDT):** IDT, consisting of the member, the legal AR, the family, service providers and other people invited by the member and the legal authority representative, if applicable.
12. **Immediate Family Member:** Father (includes natural or adoptive father, father-in-law, stepparent), mother (includes natural or adoptive mother, mother-in-law, stepparent), brother (includes half-brother, step-brother), sister (includes half-sister, step-sister), son or daughter, step-son or step daughter, adoptive son or daughter, natural grandfather, and natural grandmother and spouse relationship to the individual.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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13. **Incident Report:** Required form for documenting all reportable incidents of abuse, neglect, exploitation, death, expected and unexpected, environmental hazard, law enforcement intervention and emergency services.

14. **Medical Assistance Division (MAD):** The MAD, New Mexico Human Services Department.

15. **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.

16. **Nursing Facility Level of Care (NF LOC):** The member's functional level is such that two or more ADL cannot be accomplished without consistent, ongoing, daily provision, of some or all of the following levels of service: skilled, intermediate or assisted. A member must meet an NF LOC to be eligible for NF placement and CB services.

17. **Parent:** Natural or adoptive mother or father, or step-mother, step-father.

18. **Plan of Care (POC):** 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.

19. **Primary Caregiver:** The person who takes primary responsibility for someone who cannot care-fully for himself or herself. The primary caregiver may be a family member, a trained professional or another individual.

20. **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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.3. ABCB Services Requirements

These requirements apply to the services provided through the Medicaid 1115 Waiver for individuals who meet the eligibility criteria for HCBS, ABCB. These requirements clarify, interpret, and further enforce 8.308.12 NMAC, *Managed Care Program, Community Benefit*.

ABCB providers must meet all Federal requirements for HCBS providers, including the Final HCBS Settings Rule. All ABCB providers must be enrolled as a Medicaid provider as a 363 provider type.

The requirements address each service covered by the ABCB. Individuals served through this program will expect to receive services that meet these standards. Centennial Care MCOs must contract with eligible ABCB providers before rendering CBs to members. Eligible ABCB providers are those that have been approved and certified by the HSD/MAD/LTSSB, provider enrollment unit, per 8.308.2.9 NMAC *Managed Care Program, Provider Network*. Each MCO must ensure that it has an adequate statewide provider network for all ABCB Services.

These requirements define the services offered as approved by CMS. The ABCB services are supplement to the member’s natural supports and are not intended to replace family supports. The ABCB is not a 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 their health and safety. The purpose of this program is to provide assistance to individuals that require LTSS so they may remain in the family residence, in their own home, or in community residences. This program serves as an alternative to placement in an NF. The ABCB services are implemented in accordance with the person-centered Care Plan as developed by the member and the MCO Care Coordinator. The person-centered Care Plan must revolve around the individual ABCB member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.4. ABCB Covered Services

All ABCB services are subject to the approval of the MCO/UR. Below is a list of ABCB covered services for members in ABCB, followed by detailed service descriptions:

- Adult Day Health;
- Assisted Living;
- Behavior Support Consultation;
- Community Transition Services;
- Emergency Response;
- Employment Supports;
- Environmental Modifications;
- HH Aide;
- Nutritional Counseling;
- Personal Care – Consumer Directed;
- Personal Care – Consumer Delegated;
- Private Duty Nursing;
- Respite RN;
- Respite; and
- Skilled Maintenance Therapy Services.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.5. 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 POC incorporated into the CCP. Adult Day Health settings must be integrated and support full access of individuals receiving Medicaid HCBS to the greater community, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. The services are generally provided for two or more hours per day on a regularly scheduled basis, for one 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.

Scope of Services

- 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:
 - Coordination of transportation to and from the Adult Day Health center;
 - Activities that promote personal growth;
 - Activities that enhance the member’s self-esteem by providing opportunities to learn new skills and adaptive behaviors;
 - Supervision of self-administrated medication as determined by the New Mexico Nurse Practice Act;
 - Activities that improve capacity for independent functioning;

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- Activities that provide for group interaction in social and instructional programs and therapeutic activities;
 - PCS;
 - Meals that do not constitute a “full nutritional regime” of three (3) meals per day;
 - Intergenerational experiences;
 - Involvement in the greater community; and
 - Providing access to community resources as needed.
- Activities shall be planned by the member, family, caregivers, volunteers, staff and other interested individuals and groups. The provider must ensure safe and healthy conditions for activities inside or outside the facility.
 - An IDT meeting for each member will occur at least quarterly to review ongoing progress of direct services and activities. The POC will be adjusted as necessary to meet the needs of the member at the quarterly meeting or at other times as needed. A POC will be developed with identified goals and measurable objectives. It will be attached to or incorporated in the Care Plan.
 - All activities must be supervised by program staff. Members must never be left unattended. An Adult Day Health center staff member must be physically present with the member(s) at all times.
 - Activities must be designed to meet the needs of the member and enhance the member’s self-esteem by providing opportunities to:
 - Learn new skills and adaptive behaviors;
 - Improve or maintain the capacity for independent functioning;
 - Provide for group interaction in social and instruction programs and therapeutic activities; and

Agency Provider Requirements.

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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Adult day health facilities must be licensed by Department of Health (DOH) as an adult day care facility pursuant to 7 NMAC 13.2. 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.
- 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.).
- Adult Day Health Centers must comply with all applicable cities, county or state regulations governing transportation services.
- Adult Day Health Centers must comply with the HSD/MAD requirements including but not limited to: OSHA training requirements; incident management reporting; criminal background check (CBC); labor laws, etc. In order to be approved and certified by the HSD/MAD LTC provider enrollment unit, Adult Day Health Centers must be operating with a fully approved permanent license. Incomplete applications to the HSD/MAD LTC provider enrollment unit shall be rejected and not considered for review until a complete application is submitted.
- 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.
- The MCO will provide a copy of the Care Plan to the Adult Day Health Services Provider.
- A written Adult Day Health Services 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.
- The provider must be culturally sensitive to the needs and preferences of the member. Communicating in a language other than English may be required.

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 ensure 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.

Limits or Exclusions

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	--	--

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

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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8.6. 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 CCP. Assisted living services include ADLs (i.e., ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting, and transferring) and IADLs (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; and
- Providing safe community outings or activities.

Scope of Services

- Core services provide assistance to the member in meeting a broad range of activities of daily living. Specific services may include the following:
 - Personal Hygiene;
 - Dressing;
 - Eating;
 - Socialization;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Opportunities for individual and group interaction;
- Housekeeping;
- Laundry;
- Transportation;
- Meal preparation and dining;
- 24-hour, on-site response capability to meet scheduled or unpredictable participant needs;
- Capacity to provide on-going supervision of the ABCB member within a 24-hour period;
- Coordination of access to services not provided directly;
- Participation in the IDT meetings for development of the CCP;
- Implementation of the plan to meet the needs, evaluation for effectiveness, and adaptation as needs change.;
- 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; and/or
- Direct services provide assistance to the member in meeting a broad range of ADLs. 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 POC, that is separate from the CP, and might include:
 - Private Duty Nursing services for Adults (see the ABCB Service Standards for Private Duty Nursing);
 - Skilled Maintenance Therapies for Adults (see the ABCB Service Standards for Skilled Maintenance Therapies); and/or
 - The cost of room and board is not a covered service in Assisted Living.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

Provider Qualifications

- 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 homelike and the environment described below.
- 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; CBCs; employ abuse registry; incident management reporting; OSHA training requirements, etc. In order to be approved and certified by the HSD/MAD LTC provider enrollment unit, Assisted Living facilities must be operating with an approved permanent license. Provider agencies must comply with the provisions of Title II and III of the ADA of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- 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 such nursing requires a license, etc.).
- 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 POC.
- The Assisted Living provider will develop a POC 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 member's change. The POC is separate and incorporated into the Care Plan.
- The Assisted Living provider will develop a written agreement with each ABCB member residing in their assisted living facility. This agreement will detail all aspects of care to be provided including identified risk factors. Members shall be afforded the same protections from eviction as all tenants under landlord law of state, county, city or other designated entity. It will also include the financial agreement regarding the cost of room and board and the funding sources. A copy of this agreement and any later revisions must be forwarded to the



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

MCO Care Coordinator and must be maintained in the member's file with the MCO. The original is maintained in the member's file at the assisted living residence.

- Definition of Homelike Environment: A homelike 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 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;
 - 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;
 - 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;
 - Kitchens must be furnished with a sink, a refrigerator, at least a two burner stove top or 1.5 cubic foot microwave oven;
 - Each unit must be equipped with an emergency response system;
 - Common living areas must be smoke free;
 - Floor plans must be submitted to the HSD/MAD along with the Medicaid Provider Participation Application or renewal; and
 - In addition, CMS requires residential settings located in the community to provide members with the following:
 - 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 HCBS in more than one residential setting appropriate to their needs; Private or



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

semi-private bathrooms that include provisions for privacy; Common living areas and shared common space for interaction between participants, their guests, and other residents; Members must have access to food storage or food pantry area at all times; Members must have the freedom and support to control their own schedules regarding their day to day activities including having visitors of their own choosing at any time, when and what to eat, in their home and in the community; and 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.

- In provider owned or controlled residential settings, the following additional conditions will be provided to members: Privacy in sleeping or living unit; Units have lockable entrance doors, with members and appropriate staff having keys to doors; Members share units only at the member's choice and have a choice of roommates in that setting; Members have freedom to furnish and decorate sleeping or living units as specified in the lease or agreement; and The setting is physically accessible to the member.
- Any modification of the above conditions must be supported by a specific need and justified and documented in the POC to address the following:
 - Identify a specific and individualized assessed need;
 - Document the positive interventions and supports used prior to any modifications to the POC;
 - Document less intrusive methods of meeting the need that have been tried but did not work;
 - Include a clear description of the condition that is directly proportionate to the specific assessed need;
 - Include regular collection and review of data to measure the ongoing effectiveness of the modification;

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include the informed consent of the individual; and
- Include an assurance that interventions and supports will cause no harm to the individual.

Reimbursement

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

- Room and Board
 - The ABCB does not reimburse for room and board costs for the member (such as rent, groceries, etc.);
 - Room and board rates billed to the ABCB services must be reported to the HSD/MAD along with the Medicaid PPA 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;
 - The provider agency must comply with all state and Federal guidelines regarding the establishment of room and board rates to the ABCB services recipients; and
 - Training on member specific issues is reimbursable.
- Non-Billable Activities
 - The Assisted Living Services provider will not bill MCO for Room and Board;
 - General training requirements are an administrative cost and not billable; and
 - The Provider will not bill when an individual is hospitalized or in an institutional care setting.

Limits or Exclusions

Assisted Living services will not include the following ABCB services:

- Personal care;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Respite;
- Environmental Modifications; and
- 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. Assisted Living services will not be approved retro-actively.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.7. Behavior Support Consultation

A Behavior Support Consultant (BSC) is a licensed professional as specified by applicable State laws and standards. Behavior support consultation services assist the member and his or her family as well as the direct support professionals (DSP). Behavior support consultation services for the member include:

- Assessments;
- Evaluations;
- treatments;
- Interventions; and
- 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.

Scope of Services

- Behavior support consultation services are initiated when the MCO Care Coordinator identifies and recommends the service be provided to the member/member’s representative. The Care Coordinator is responsible for including recommended units of behavior support consultation services. It is the responsibility of the participant/participant representative, and Care Coordinator, to ensure units of therapy do not exceed the capped dollar amount determined for the participant/participant representative’s 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.
- Behavior support consultation services include:
 - 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;
 - Designing, modifying and monitoring the use of related activities for the participant/participant representative that is supportive of the Care Plan;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Training families and DSPs in relevant settings as needed for successful implementation of therapeutic activities, strategies, and treatments;
- Consulting with the IDT member(s), guardians, family, or support staff;
- Consulting and collaborating with the participant/participant representative's 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;
- 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; and
- Services may be provided in a clinic, home, or community setting.
- Comprehensive Assessment Guidelines:
 - 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.
- Attendance at the IDT Meeting:
 - The BSC is responsible for attending and participating, either in person or by conference call in IDT meetings convened for service planning;
 - 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; and
 - 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.
- Discharge Planning Documentation Includes:



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Reason for discontinuing services (such as failure to participate, request from participant/participant representative, goal completion, and/or failure to progress);
- Written discharge plan shall be provided to the participant/participant representative and the MCO Care Coordinator by the BSC;
- Strategies developed with participant/participant representative that can support the maintenance of behavioral support activities;
- Family and direct support professional training that is completed in accordance with the written discharge plan; and
- 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.
- Agency/Individual Provider Requirements:
 - 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; and
 - The agency must maintain a current provider status through the HSD/MAD Provider Enrollment Unit. Contact Provider Enrollment Unit for details.
- Agency/Individual Administrative Requirements
 - BSC Requirements:
 - 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.
 - Acceptable licensure includes:
 - New Mexico Licensed Psychologist or Psychologist Associate.
 - New Mexico Licensed Independent Social Worker (LISW).
 - New Mexico Licensed Master Social Worker (LMSW).



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- New Mexico Licensed Professional Clinical Counselor (LPCC).
- New Mexico Licensed Marriage and Family Therapist (LMFT).
- 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; and
- Licensed BSCs identified in Section 8.7 of this Manual may provide billable behavior support consultation services.
- Documentation:
 - Documentation must be completed in accordance with applicable HSD/MAD and Federal guidelines;
 - All documents are identified by title of document, participant name, and date of documentation. Each entry will be signed with appropriate credential(s) and name of person making entry;
 - Verified Electronic Signatures may be used. BSC name and credential(s) typed on a document is not acceptable;
 - All documentation will be signed and dated by the BSC providing services;
 - A copy of the annual evaluation and updated treatment plan will be provided to the MCO Care Coordinator within 10 business days following the IDT meeting. The treatment plan must include intervention strategies, as well as frequency and duration of care. The goals and objectives must be measurable;
 - 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;
 - 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;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Any modifications that need to be included in the Care Plan must be coordinated with the MCO Care Coordinator;
 - 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/health care provider as indicated;
 - Each participant will have an individual clinical file maintained by the provider;
 - Review physician/health care provider orders at least annually and as appropriate, and recommend revisions on the basis of evaluative finding; and
 - Copies of BSC contact notes and BSC documentation may be requested by HSD/MAD for assurance purposes.
- **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 ensure the information on the prior authorization for their services is current. If the provider identifies an error, they will contact the MCO immediately to have the error corrected. HSD/MAD does not consider the following to be professional BSC duties and will not authorize payment for:
- Performing specific errands for the participant/participant representative or family that is not program specific;
 - Friendly visiting, meaning visits with the participant outside of work scheduled;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Financial brokerage services, handling of participant finances or preparation of legal documents;
- Time spent on paperwork or travel that is administrative for the provider;
- Transportation of participant/participant representative;
- Pick up and/or delivery of commodities; and
- Other non-Medicaid reimbursable activities.

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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8.8. Community Transition Services

Community Transition Services are non-recurring set-up expenses for adults 21 years old and older who are transitioning from an SNF to a living arrangement in the community where the person is directly responsible for his or her own on-going living expenses.

This service is not intended to cover the household costs of the member's natural supports.

Allowable expenses are those necessary to enable a member to establish a basic household. Community Transition Services are furnished only when the member is unable to meet the expenses to establish his/her household or when the services cannot be obtained from other sources. Community Transition Services may not be used to furnish or establish living arrangements owned or leased by a service provider, except an assisted living facility. Deposits to an assisted living facility are limited to \$500.00. Services must be reasonable and necessary as determined by the MCO and authorized in the Care Plan.

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:

- 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;
- Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- Services necessary for the individual's health and safety such as but not limited to, pest eradication and one-time cleaning prior to occupancy;
- Moving expenses; and/or

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

- Fees to obtain a copy of birth certificate, identification card or driver’s license.

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 an NF to a home and community-based residence. The CTA must be able to provide at least two of the following core services:

- Information and referral;
- Independent living skills training;
- Peer counseling;
- Individual and systems advocacy; and
- CTAs include but are not limited to Centers for Independent Living and Area Agencies on Aging.

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.

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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

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 an NF stay of at least 90 days prior to transition to the community. Payment for a deposit to an assisted living facility is limited to \$500.00.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.9. 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 24 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.

Scope of Services

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

Agency Provider Requirements

- Emergency Response Service providers must comply with all laws, rules and regulations of the New Mexico state corporation commission for telecommunications and security systems, if applicable.
- Provider agencies must establish and maintain financial reporting and accounting for each member.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

- 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.
- The agency will have security bonding.
- 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.
- 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.

Reimbursement

- 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.
- A monthly fee charged for each calendar month of use ongoing through entirety of a contractual agreement.
- A fee for special equipment (e.g., aa bracelet rather than a necklace) must be medically necessary and must be substantiated and authorized by the MCO. This is designated as Emergency Response – High Need. The reason(s) for high need emergency response services must be documented in the CCP.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.10. 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.

Scope of Services

Supported employment facilitates competitively work in integrated work settings for individuals with disabilities (i.e., psychiatric, mental retardation, learning disabilities, and TBI) for whom competitive employment has not traditionally occurred, and who, because of the nature and severity of their disability, need ongoing support services in order to perform their job.

Employment Supports settings must be integrated and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and provide access to services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Supported employment provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

- Basic Components

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

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:

- **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.
- **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 ensure 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 the vocational rehabilitation service'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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Members are still eligible for accessing Community Services in conjunction with Employment Supports.

Agency Provider Requirements

- Provider Agency Records: The provider adheres to the Department of Labor 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.
- The Provider Agency shall maintain a confidential case file for each individual and will include the following items:
 - Quarterly progress reports;
 - 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 the Division of Vocational Rehabilitation (DVR) or HSD/MAD; and
 - 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.
- Provider Agency Reporting Requirements

The Supported Employment Provider Agency shall submit the following to the MCO Care Coordinator:

- Quarterly Progress Reports based upon the individual’s Care Plan cycle;
- Vocational Assessment; and

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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- Written updates, at least every six months, to the Work/Learn Action Plan.

- 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.

- Staffing Requirements (Individual to Staff Ratio)

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.

- 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.

- 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.

- Qualification and Competencies for Employment Supports Staff: Qualifications and competencies for staff providing job coaching/consultation services shall, at a minimum, be able to:

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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Employ job-coaching techniques and to help the individual learn to accomplish job tasks to the employer's specifications;
- Increase the individual's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
- 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;
- Identify specific information about the individual's interests, preferences and abilities;
- 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;
- 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;
- Address behavioral, medical or other significant needs identified in the Care Plan that require intensive one-on-one staff support;
- Communicate effectively with the individual including communication through the use of adaptive equipment if applicable, at the work site;
- 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;
- Adhere to relevant state policies/standards and Provider Agency policies and procedures that directly impact services to the individual;
- Model behavior, instruct and monitor any work place requirements to the individual;
- Adhere to professionally acceptable business attire and appearance, and communicate through interactions a business-like, respectful manner; and
- Adherence to the rules of the specific work place, including dress, confidentiality, safety rules, and other areas required by the employer.

Reimbursement

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Employment Supports provider agencies must maintain appropriate record keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursements for employment support services will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and ensure 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.

Limits or Exclusions

Payment shall not be made for incentive payments, subsidies, or unrelated vocational training expenses such as the following: incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program, payments that are passed through to users of supported employment programs, or 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.11. 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.

Scope of Services

Environmental modifications are physical adaptations and environmental control systems excluding DME. 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 exclude such things as carpeting, roof repair, furnace replacement, remodeling bare rooms, and other general household repairs.

Agency Provider Requirements

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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

working knowledge of environmental modifications and be familiar with the needs of persons with functional limitations in relation to environmental modifications.

- The environmental modification provider must ensure proper design criteria as addressed in planning and design of the adaptation. 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;
- 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.
- The environmental modification provider must establish and maintain financial reporting and accounting for each member.
 - The environmental modification provider will submit the following information and documentation to the MCO:
 - Environmental modification evaluation;
 - 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);
 - Letter of Acceptance of service cost estimate signed by the member;
 - 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;
 - 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;
 - Documentation demonstrating compliance with the ADA.
- The Provider must submit the following to the MCO, after the completion of work:
 - Letter of approval of work completed signed by the member; and
 - Photographs of the completed modifications.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- The MCO must submit the Care Coordinator Individual Assessment of Need to the provider.

Care Coordinator Reimbursement

Environmental modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid PPA. Billing is on a project basis, One 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 ensure 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.

Limits or Exclusions

Environmental modification services are limited to \$5,000.00 every five years. Administrative Costs of the provider for environmental modification services will not exceed 15% of the total cost of the environmental modification project for each project managed by the MCO.

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.

This service cannot be used to fund new construction including apartment buildings and Assisted Living facilities.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.12. Home Health Aide

Home Health Aide (HH Aide) Services provide total care or assist an eligible member in all ADLs. 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.

Scope of Services

The HH Aide services assist the eligible member in a manner that promotes an improved quality of life and a safe environment for the eligible member. HH Aide services can be provided outside the eligible member's home. State Plan HH Aide services are intermittent and provided primarily on a short-term basis; whereas, HH Aide services are provided hourly, for eligible members who need this service on a long-term basis. HH Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. HH 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.

HH aide services must be provided under the supervision of an RN 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.

Agency Provider Requirements

- The HH Agency (HHA) must be an approved provider with HSD/MAD and licensed by the DOH as an HHA.
- HHA Qualifications:
 - 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;
 - HHA training at the licensed HH Agency which follows the Federal HHA training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2., or;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- A CNA who has successfully completed the employing HH Agency's written and practical competency standards and meets the qualifications for an HHA. Documentation will be maintained in personnel file; or
- An HHA who was not trained at the employing HHA will need to successfully complete the employing HHA's written and practical competency standards before providing direct care services. Documentation will be maintained in personnel file; or
- The HHA will be supervised by the HH Agency RN supervisor or HHA RN designee at least once every two weeks in the member's home; or
- 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.
- All supervisory visits/contacts must be documented in the member's HHA clinical file on a standardized form that reflects the following:
 - Service received;
 - Member's status;
 - Contact with family members; and
 - Review of HHA POC with appropriate modification annually and as needed.
- Requirements for the HH Agency Serving ABCB Population:
 - The HHA nursing supervisors(s) should have at least one year of supervisory experience. The RN supervisor will supervise the RN, LPN and HHA;
 - The HHA 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;
 - The HHA will document and report any noncompliance with the Care Plan to the MCO Care Coordinator;

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	--	---

- 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;
- The HHA 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;
- The HHA and MCO Care Coordinator must have documented monthly contact that reflects the discussion and review of services and ongoing coordination of care;
- The HHA supervising RN, direct care RN and LPN shall train families, DSP 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; and
- It is expected the HHA will consult with, IDT members, guardians, family, and DSPs as needed.

Reimbursement

HH aide provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for HH 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.13. Nutritional Counseling

Nutritional Counseling services are designed to meet the unique food and nutritional needs of CB members. This does not include oral-motor skill development services, such as those provided by a speech pathologist.

Scope of Services

- Assessment of nutritional needs;
- Development and/or revision of the member’s nutritional plan; and
- Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.

Nutritional Counseling Qualifications - Individual Provider

- Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.

Nutritional Counseling Qualifications - Agency Provider

- Current business license; and provide a tax identification number;
- Ensure staff meet the following qualifications; and
- Licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.14. Personal Care Services

Scope of Services

PCS have been established by HSD/MAD or Medicaid to assist individuals 21 years of age or older who are eligible for full Medicaid coverage and meet the NF 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 IADLs.

- The MCO determines medical LOC for PCS eligibility upon initial application and at least annually thereafter. Medicaid-eligible individuals may contact the MCO to apply for PCS.
- 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.
- PCS is a Medicaid service, not a Medicaid category of assistance, and services are delivered pursuant to an Individual Plan of Care (IPoC). PCS includes 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 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.
- PCS providers will use the HSD approved EVV system to record date and time for provided PCS. PCS agencies are responsible for establishing employment policies and providing oversight of employees to ensure the required use of EVV as mandated in the 21st Century Cures Act.

Eligible Population

To be eligible for PCS, a member must meet all of the following criteria:



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Be a recipient of a full benefit Medicaid category of assistance and, not be receiving other Medicaid HCBS waiver benefits, Medicaid NF, ICF/IID Medicaid, PACE, or APS attendant care program, at the time PCS are furnished; an individual residing in an 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;
- Be age 21 or older;
- Be determined to have met NF LOC by the MCO; and
- Comply with all Medicaid and PCS regulations and procedures.

LOC Determination

To be eligible for PCS, a consumer must meet the LOC required in an NF. The MCO makes initial LOC determination and subsequent determinations at least annually thereafter.

- 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.
- Any individual applying for PCS who has an existing approved NF LOC determination in another program (i.e., NF) will not need an additional LOC determination until his/her next annual assessment.
- 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.
- 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- 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.

Service Delivery Models – Consumer-Delegated PCS and Consumer-Directed PCS

- Consumers eligible for PCS have the option of choosing the **consumer-delegated** or the **consumer-directed** personal care model. In both models, the consumer may select a family member (except the spouse), a friend, neighbor, or other person as the attendant. The MCO's Care Coordinator is responsible for explaining both models to each consumer, initially, and annually thereafter.
 - 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.

Consumer's Responsibilities

Consumers receiving PCS have certain responsibilities depending on the service delivery model they choose.

- The consumer's or legal representative's responsibilities under the consumer-delegated model include:
 - Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
 - Allowing the PCS provider to complete monthly home supervisory visits;
 - 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;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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
- Complying with all Medicaid rules, regulations, and PC service requirements; failure to comply may result in discontinuation of PCS.
- The consumer's or legal representative's responsibilities under the consumer-directed model include:
 - Interviewing, hiring, training, terminating, and scheduling personal care attendants; this includes, but is not limited to:
 - Verifying 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 identification is kept in the attendant's personnel file at all times;
 - Verifying 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;
 - Identifying training needs; this includes training his/her own attendant(s) or arranging for training for the attendant(s);
 - 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;
 - Verifying 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;
 - Notifying the agency, within one business day, of the date of hire or the date of termination of his/her attendant and ensure all relevant employment paperwork and



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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;

- Notifying and submitting a report of an incident to the PCS agency within 24 hours of such incident, so 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;
- Ensuring 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.
- Obtaining a signed agreement from the attendant, 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;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Ensuring 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;
- Signing an agreement accepting responsibility for all aspects of care and training including mandatory training in cardiopulmonary resuscitation (CPR), first aid for all attendants, MH first aid training, competency testing, tuberculosis (TB) testing, Hepatitis B immunizations, or waiving the provision of such training and accepting the consequences of such a waiver;
- 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.;
- Allowing the MCO to complete assessment visits and other contacts necessary to avoid a lapse in services;
- Allowing the PCS provider to maintain at least a minimum of quarterly in-person contact;
- 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;
- 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
- Complying with all Medicaid rules, regulations, and PCS requirements.



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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.

Agency Provider Requirements

- Eligible PCS Agencies: PCS agencies electing to participate in providing PCS must obtain agency certification.
- 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. A PCS agency may only serve members in the counties that are approved by HSD. 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. Upon HSD approval, 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.
- 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:



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- A completed Medicaid PPA (also known as the MAD 335);
- 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; 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;
- 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); and
- A copy of written policies and procedures that address:
 - Medicaid’s PCS provider rules and regulations;
 - Personnel policies; and
 - Office details that include but are not limited to:
 - 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;
 - Meeting all ADA requirements; and
 - If PCS agencies have branch offices, the branch office must have a qualified onsite administrator to handle day-to-day operations and receive direction and supervision from the main/central office;
- Quality improvement (QI) to ensure adequate and effective operation, including documentation of quarterly activity that addresses, but is not limited to:
 - Service delivery;
 - Operational activities;
 - Critical incident and significant events management practices;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- QI action plan;
- Documentation of QI activities;
- Agency operations to furnish services as consumer-directed or consumer-delegated, or both;
- A copy of a current and valid home health license, issued by the DOH, Division of Health Improvement, licensing, and certification (pursuant to 7.28.2 NMAC) may be submitted in lieu of the requirements; if certified, a copy of a current and valid home health license must be submitted annually along with proof of liability and workers' compensation insurance; and
- 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:
 - Communication skills;
 - Patient/member rights, including respect for cultural diversity;
 - Recording of information for patient/client records;
 - Nutrition and meal preparation;
 - Housekeeping skills;
 - Care of the ill and disabled, including the special needs populations;
 - Emergency response (including CPR and first aid);
 - Universal precautions and basic infection control; home safety including oxygen and fire safety;
 - Incident management and reporting; and
 - Confidentiality.
- 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;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

this will require the agency to attend a mandatory Medicaid or its designee's provider training session prior to the delivery of PCS.

- An agency will not be certified as a personal care agency if:
 - 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; and
 - 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:
 - 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); step-mother, step-father, mother-in-law, father-in-law (first degree by marriage); step-brother, step-sister, 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); and
 - 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.
- 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:
 - Furnishing services to Medicaid consumers that comply with all specified Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies and 8.308.2.9 NMAC, Provider Network Policies;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
- Using the HSD-approved EVV system;
- Maintaining appropriate recordkeeping of services provided and fiscal accountability as required by the PPA;
- 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;
- The PCS agency will, unless exempted by MAD or its designee, use an electronic system attendants will use to check in and check out at the end of each period of service delivery; the system must produce records that can be audited to determine the time of services provided, the type of services provided, and verification by the consumer or the consumer's legal representative; failure by a PCS agency to maintain a proper record for audit under this system will subject the PCS agency to recovery by Medicaid of any insufficiently documented claims;
- 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;
- Providing either the consumer-directed or the consumer-delegated models, or both models;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Furnishing to their consumers, upon request, information regarding each model; if the consumer chooses a model 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;
- Ensuring each consumer receiving PCS services has a current IPoC on file;
- 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;
- Producing reports or documentation as required by Medicaid or its designee;
- Verifying consumers will not be receiving services through the following programs while they are receiving PCS: Medicaid HCBS through the DD or MF waivers; Medicaid certified NF, ICF/IID, PACE, or APS attendant care program; recipients of community transition goods or services may receive Planning Center Online (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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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;

- Processing all claims for PCS in accordance with the billing specifications from the MCO; payment shall not be issued without appropriate documentation;
- 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; and
- 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:
 - 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;
 - Neglect is defined as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness to a consumer;
 - 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; and
- Submit 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:
 - Death of the consumer:
 - Unexpected death is defined as any death of an individual caused by an accident, or an unknown or unanticipated cause; and/or



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
- Other reportable incidents:
 - Environmental hazard is defined as an unsafe condition that creates an immediate threat to life or health of a consumer;
 - 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;
 - 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 PCP; and/or
 - Any reports made to APS.
- Informing the consumer and his/her attendant of the responsibilities of the agency;
- Developing an IPoC based on the assessment, services authorization, task list, and consideration of natural supports provided by the MCO;
- Providing an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;
- 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
- Maintaining documentation in the consumer's file regarding legal and personal representatives, as applicable.
- For agencies providing PCS under the consumer-directed model, the responsibilities include:



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
 - 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;
 - Fiscal employer agent (FEA) in which the consumer is the legal employer of record (EOR) and the managing employer; and the agency maintains at least quarterly in-person contact with the consumer;
- 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;
- Obtaining a signed agreement from each consumer accepting responsibility for all aspects of care and training, including mandatory training in CPR, first aid for all attendants, MH first aid training, 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;
- 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 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 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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;

- Establishing and explaining to the consumer necessary payroll documentation for reimbursement of PCS;
 - 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;
 - Arranging for unemployment coverage and workers' compensation insurance;
 - 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;
 - 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
 - Maintaining a consumer file, and an attendant personnel file for the consumer, for a minimum of six years.
- For agencies providing PCS under the consumer-delegated model, the responsibilities include, but are not limited to the following:
 - Employing, terminating, and scheduling qualified attendants; and/or
 - 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:
 - An overview of PCS;
 - Living with a disability or chronic illness in the community;
 - CPR, first aid training, and MH first aid training;
 - A written competency test with a minimum passing score of at least 80%; expenses for all training are to be incurred by the agency; other training may take place



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
- Documentation of all training must include at least: name of trainee, title of the training, source, number of hours, and date of training;
 - 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%; 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;
 - 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;
 - Informing the attendant of the risks of Hepatitis B infection per current DOH or the Centers 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;
 - Obtaining a copy of the attendant's current and valid State driver's license or other current and valid State photo identification 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;
 - Complying with Federal and state labor laws;
 - Preparing all documentation necessary for payroll;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Complying with Medicaid participation requirements outlined in 8.302.1 NMAC, General Provider Policies;
- 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;
- 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;
- Ensuring, 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;
- Establishing and explaining to all their consumers and all attendants the necessary documentation needed for reimbursement of PCS;
- Performing payroll activities for the attendants;
- Providing workers' compensation insurance for attendants; and/or
- 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:
 - Date of visit;
 - Time of visit to include length of visit;
 - Name and title of person conducting supervisory visit;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Individuals present during visit;
- Review of IPoC;
- Identification of health and safety issues and quality of care provided by attendant, and
- Signature of consumer or consumer's legal representative;
- Maintaining an accessible and responsive 24-hour communication system for consumers to use in emergency situations to contact the agency;
- Following current recommendations of DOH and CDC, as appropriate, for preventing the transmission of TB; and
- 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.
- 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:
 - Being hired by the consumer (consumer-directed model) or the PCS agency (consumer-delegated model);
 - Not being the spouse of a consumer, pursuant to 42 CFR Section 440.167;
 - Providing the consumer (consumer-directed), or the PCS agency (consumer-delegated), with proof and copies of their current valid state driver's license or current valid state photo identification, and if the attendant will be transporting the consumer, current valid driver's license and current motor vehicle insurance policy;
 - Being 18 years of age or older;
 - Ensuring, 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 PCS provided by the consumer's legal representative must be justified, in writing, by the PCS agency, and



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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 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;

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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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);
- 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;
- Following current recommendations of DOH and CDC, as appropriate for preventing the transmission of TB;
- For consumer-delegated care only, completing 12 hours of training yearly; the attendant must obtain certification of CPR, first aid training and MH 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 must successfully pass a written personal care attendant competency test with at least 80% correct within the first three months of employment; and
- Use the EVV system to document when and where PCS were provided to the member.
- 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

services must be directly related to an individual's functional level to perform ADLs and IADLs as indicated in the CNA.

- 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 HH or other State plan or LTC 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 the PCS does 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.
- PCS are not furnished to an individual who is an inpatient or resident of a hospital, NF, ICF/IID, MH facility, correctional facility, other institutional settings, except for recipients of community transition goods or services.
- 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:
 - 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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.
- 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.
 - 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.
 - 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. Description of PCS refers to 8.308.12.13 NMAC.



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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:

- There is a change in the consumer's condition (either improved or declined);
 - There is a change in the consumer's natural supports or living conditions;
 - Upon the consumer's request; and/or
 - The MCO must explain each service delivery model at least annually to consumers enrolled in ABCB.
- The MCO will issue a prior authorization to the PCS agency. A PCS authorization cannot extend beyond the LOC period and must be provided to the PCS agency prior to the prior authorization effective date and may not be applied retroactively.
 - 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.
 - 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 10 calendar days of the date of the Notice of Action.
 - 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 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.
- 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.



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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

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

- The PCS agency must:
 - 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;
 - Ensure the consumer has participated in the development of the plan and the IPoC is reviewed and signed by the consumer or the consumer's legal representative; a consumer's signature on the IPoC indicates 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;
 - 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
- Submit the IPoC to the MCO for review if the IPoC varies from the PCS Allocation Tool; Provide the consumer with a copy of their approved IPoC;
 - Obtain an approved task list and/or CNA;
 - Obtain written verification the consumer, or the consumer's legal representative, understands 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
 - 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.
- PCS are to be delivered only in the State of New Mexico. However, consumers who require PCS out of the state, for medically necessary reasons, may request an exception, and must obtain written approval from the MCO for out of state delivery of service prior to leaving the state. The following must be submitted for consideration when requesting medically necessary out of state services:
 - A 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:
 - The consumer's name and SSN;
 - How time sheets/logs/check-off list will be transmitted and payroll checks issued to the attendant;
 - Date the consumer will be leaving the state, including the date of the medical procedure or other medical event, the anticipated date of return;
 - Where the consumer will be housed after the medical procedure;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- A letter or documentation from the physician, surgeon, physician assistant, nurse practitioner, or clinical nurse specialist verifying the date of the medical procedure; and
- 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.
 - Utilization Review (UR): All PCS require prior LOC approval by the MCO; therefore, retroactive services are not authorized. All PCS are subject to UR for medical necessity and program compliance. The MCO will perform UR for medical necessity. The MCO makes final authorization of PCS using:
 - The HSD-approved LOC criteria; and
 - The CNA.
- PCS Agency Transfer Process: A consumer requesting to transfer services from one PCS agency to another Medicaid-approved PCS agency may request a transfer form (MAD 062) or other approved transfer/closure form) from his/her MCO. Transfers may only be initiated by the consumer, his/her legal representative, or by a PCS agency on behalf of a consumer or his/her legal representative. Transfer requests shall not be requested by the personal care attendant. Transfer approvals are determined by the MCO and should be initiated by the consumer through the consumer's assigned Care Coordinator.

The following outlines the process for PCS Agency Transfers:

- The consumer must inform his/her MCO of the desire to transfer to another PCS agency;
- The consumer must complete a MAD 062 or an approved transfer form to include: the consumer's signature; the date of the signature of the receiving PCS agency; and the justification for the transfer;
- The MCO will process the transfer request within 15 business days after receipt of the transfer request;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- If approved, the MCO works with both the agency from which the consumer is currently receiving services (originating agency) and the agency to which the consumer would like to transfer (receiving agency) to complete the transfer;
- Originating agencies are responsible for continued provision of services until the transfer is complete;
- Upon approval of the request, the MCO will issue a new prior authorization to the receiving agency and make the transfer date effective 10 business days from the date of processing the transfer. The prior authorization will include: a new prior authorization number and new DOS 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; and

The following outlines the MCO review process for PCS agency transfers:

- When the MCO receives a request for a transfer from a consumer or PCS agency on behalf of a consumer or his/her legal representative, the consumer's Care Coordinator will interview the consumer to determine if the request is **consumer-driven**;
- The Care Coordinator will ask the consumer or his/her legal guardian for specific reasons for the transfer, including but not limited to: Will you be taking your caregiver with you? If the consumer is taking his/her caregiver, the Care Coordinator should ask why the consumer is requesting a transfer;
- The Care Coordinator will contact the originating and the receiving agency to investigate the reasons given by the consumer and/or legal representative. In addition, the Care Coordinator will ensure the consumer has notified both agencies;
- If, during the review process, the MCO determines the originating and/or receiving agency is not compliant with the applicable Medicaid regulations, the MCO shall conduct an audit of the agency and, if necessary, provide additional training or impose a corrective action plan (CAP). For example, if the receiving agency has engaged in solicitation, or if the originating agency is not sending back-up caregivers or the caregivers are not showing up on the scheduled days or for the hours care is planned for, these issues need to be addressed by the MCO and corrected by the agencies;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- If, during the course of the review process, the Care Coordinator finds that the consumer has requested three transfers within a six-month period, the Care Coordinator shall meet with the consumer and/or legal guardian to try to determine the reason for such requests and consider whether to approve or deny the transfer;
- The consumer and/or legal guardian will not be allowed to hire an individual to be his/her attendant who has not passed a nationwide criminal history screening or an attendant that has been terminated from another agency for fraudulent activities or other misconduct. The Care Coordinator will educate the consumer about the Medicaid PCS policies;
- When reviewing a transfer request, the MCO should take into consideration whether the consumer can speak and read English. If the consumer does not speak or read English, the MCO shall provide a translator to ensure the consumer's options have been explained and the consumer fully understands his/her options, and the service model selected is available to the consumer;
- The Care Coordinator should ensure the location of the agency or provider is convenient to the consumer;
- 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 continuation of benefits is requested timely by the consumer and approved by the MCO;

All requests for change of service model (from/to directed/delegated) must be approved by the MCO prior to the receiving agency providing services to the consumer; and

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

- The consumer is requesting more hours/services;
- The consumer's attendant or family member is requesting the transfer;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The consumer has requested three or more transfers within a six-month period;
 - The consumer wants his/her legal guardian, spouse or attorney-in-fact to be his/her attendant;
 - The consumer wants an individual to be his/her attendant who has not successfully passed a nationwide criminal history screening;
 - The consumer wants an attendant who has been terminated from another agency for fraudulent activities or other misconduct;
 - The attendant does not want to complete the mandated trainings under the consumer-delegated model;
 - The consumer does not wish to comply with the Medicaid or PCS regulations and procedures; and
 - There is reason to believe that solicitation has occurred as defined in this policy in the, Solicitation/Advertising Section in this Manual.
- **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.
 - **Consumer Discharge:** A consumer may be discharged from a PCS agency.
 - **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 justifiable reason for discharge may include:



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Staffing problems (i.e., excessive request for change in attendants, such as three or more during within 30 calendar days);
 - A consumer demonstrates a pattern of verbal or physical abuse toward attendants or agency personnel, including the use of vulgar or explicit (i.e., sexual) 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;
 - 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;
 - Illegal use of narcotics or alcohol abuse;
 - Fraudulent submission of timesheets; or
 - 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.
- 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.
 - 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.
 - 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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:

- 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;
- 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;
- A consumer or family member who demonstrates a pattern of uncooperative behavior including, noncompliance with agency, Medicaid program requirements or regulations or procedures;
- Illegal use of narcotics, or alcohol abuse;
- Fraudulent submission of timesheets;
- Unsafe or unhealthy living conditions or environment; and/or
- PCS agencies and the MCO are responsible for documenting and reporting any incidents involving a consumer to Medicaid or its designee.

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.

PCS Provider Voluntary Disenrollment



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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:

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

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.

- Prohibited solicitation includes, but is not limited to, the following:
 - Contacting a consumer who is receiving services through another PCS or any another Medicaid program;
 - Contacting a potential consumer to discuss the benefits of its agency, including door-to-door, telephone, mail and email solicitation;
 - 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;
 - 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;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

- Making false promises;
 - Misinterpretation or misrepresentation of Medicaid rules, regulations or eligibility;
 - Misrepresenting itself as having affiliation with another entity; and/or
 - Distributing PCS-related marketing materials.
- 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.
 - 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.

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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.15. 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 RN or a 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 POC/Treatment (CMS form 485) that is separate from the Care Plan developed by the MCO. CB service members do not have to be homebound in order to receive this service. CB 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 CB 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 CB 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 EPSDT. Specific services may include the following.

Scope of Services

- Obtaining pertinent medical history;
- Observing and assessing the member’s condition;
- Administration of medications to include: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes;
- Providing wound care, suture removal and dressing changes;
- Monitoring feeding tubes (i.e., gastrostomy, naso-gastric, or jejunostomy including patency), including signs of possible infection;
- Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Monitoring aspiration precautions;
- Monitoring administration of oxygen, ventilator management, and member's response;
- Monitoring infection control methods;
- Monitoring seizure protocols;
- Collecting specimens (blood, urine, stool, or sputum) and obtaining cultures as ordered by the member's primary physician;
- Alerting the member's physician to any change in health status;
- Monitoring nutritional status of the member and reporting any changes to the physician and nutritionist if available;
- Maintaining member intake and output flow sheets as ordered by the physician;
- Performing physical assessments including monitoring of vital signs and the member's medical condition as warranted;
- 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;
- Providing staff supervision of appropriate activities, procedures and treatment;
- The POC/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 POC/treatment (CMS form 485) on the basis of the member assessment and evaluation;
- Analyze and interpret member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings;
- Develop interventions to assist the member to achieve and promote health to meet the individual member's needs;
- Develop individualized service goals, identifying short-and long-term goals that are measurable and objective; and/or



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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

Service Requirements

- 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.
- 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 RN. Physician's orders will contain the following:
 - The task to be performed;
 - How frequently the task is to be performed;
 - The duration that the order is applicable; and
 - 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.
- The Private duty nursing supervisor will provide clinical supervision in the member's home at a minimum of once each quarter. Supervision of private duty nursing services must be documented in the member's clinical record.
- The POC/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.
- 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 POC/Treatment.
- Reviewing and revising the nursing POC/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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- 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.
- Reviewing physician’s request for treatment. If appropriate, recommend revisions to the Care Plan to the MCO Care Coordinator by requesting a conference.
- Providing member and/or caregiver education regarding services. Document the date and time this occurred in the member’s clinical file.

Agency/Individual Provider Requirements

- Staffing Requirements:
 - An RN or LPN is considered a qualified private duty nurse when the following criteria are met:
 - Must have current licensure as required by the state of New Mexico;
 - Nursing experience preferably with disabled and elderly individuals. This includes settings such as HH, hospital, NF facility, or other types of clinics and institutions;
 - Nursing services must be furnished through a licensed HH Agency, licensed RHC or certified FQHC;
 - RNs who supervise should have at least one year of supervisory experience. Supervision of LPNs must be provided by an RN 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;
 - 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; and
 - 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.
- Administrative Requirements:

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- Must comply with all applicable State and Federal rules and regulations for licensed HH agencies and program standards determined by HSD/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.;
- All services must be under the order of the member’s PCP. 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; and
- Reports must be current and available upon request of HSD/MAD.

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 ensure 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.

- Payment for private duty nursing services through the MCO is considered payment in full.
- Private duty nursing services must abide by all Federal, state, HSD, policies and procedures regarding billable and non-billable items.
- Billable hours are as follows:
 - Face-to-face activities that are described above in the scope of service for private duty nursing;
 - Attendance and/or telephone conference call to participant in IDT meetings;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Development of the POC/Treatment, not to exceed four hours annually;
- Reimbursement is on a unit rate per hour and rounded to the nearest quarter; and
- Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- 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:
 - Performing specific errands for the individual and/or family that are not program specific;
 - Friendly visiting;
 - Financial brokerage services, handling of member finances, or preparation of legal documents;
 - Time spent on paperwork or travel that is administrative for the provider;
 - Transportation of members;
 - Pick up and/or delivery of commodities; and
 - Other non-Medicaid reimbursable activities.
- Private duty nursing services are provided with the understanding that the MCO is the payer of last resort. ABCB services should not be requested or authorized until all other third party and community resources have been explored and/or exhausted. If services are available for reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.
- Private duty nursing services ensure all insurance records are maintained correctly.
- Reimbursement for private duty nursing services will be based on the current contract negotiated with the MCO for the services. Providers of service have the responsibility to review and ensure 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.
- 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

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

other funding sources for nursing such as Medicare or private pay etc., to supplement ABCB service nursing services for a member.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.16. 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 an RN, or an LPN. Nursing respite and respite services are limited to a total maximum of 300 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;

Scope of Services

- Assistance with routine ADLs such as bathing, eating, meal preparation, dressing, and hygiene;
- Assistance with routine IADLs such as general housekeeping;
- Assistance with PCS or private duty nursing services, based on the member’s needs;
- Assistance with the enhancement of self-help skills; and
- Assistance with providing opportunities for leisure, play and other recreational activities.

Service Requirements

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

Agency Provider Requirements

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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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.

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.

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.

Supervision of nursing respite services will be done at least quarterly. An RN must supervise private duty nursing respite employees. The supervisory nurse must be on the staff or an MCO of the provider agency to supervise and provide in-service training to the personnel providing the care.

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.

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.

Authorization of Nursing Respite Care Services

Scheduling of hours for use of nursing respite services will be the responsibility of the nursing respite service provider and the member.

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 private duty nursing and shared with the MCO. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement. The provider of nursing respite services must maintain a cumulative record of utilization of respite care, to include time used.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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The member cannot schedule his or her own respite with the nursing respite staff. The member may receive a maximum of 300 total hours of nursing respite and hours annually per Care Plan year provided there is a primary caregiver.

Reimbursement

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.

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 ensure 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.

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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8.17. Respite Services

Respite services provide the member’s primary caregiver with a limited leave of absence to prevent burnout, to reduce stress and provide temporary relief to meet a family crisis, emergency or caregiver’s illness as determined in the CCP. A primary caregiver is the individual who has been identified in the CCP and who assists the member on a frequent basis (i.e., daily or at a minimum, weekly). Respite provides a temporary relief to the primary caregiver during times when he/she would normally provide unpaid care. If a caregiver needs a break during the time when he/she provides paid care, the agency must provide a substitute caregiver. Respite services may be provided in the member’s home, in the respite provider’s home and in the community. Nursing respite and respite services are limited to a total maximum of 300 hours per CCP year. Respite services must not be provided by a member of the member’s household or by any relative approved as the paid caregiver. Respite services are provided pursuant to the CCP, developed and authorized by the recipient of service and the MCO Care Coordinator. Additional hours may be requested if an eligible member’s health and safety needs exceed the specified amount.

Specific Respite services may include the following:

Scope of Services

- 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 rooms in a house of six 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:
 - Sweeping, mopping or vacuuming of carpets, hardwood floors, or linoleum;
 - Dusting of furniture;
 - Changing of linens;
 - Doing laundry (member’s clothing and linens only);



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Cleaning bathrooms (tub and/or shower area, sink, and toilet); and/or
- 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.
- 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.
- Personal Care – The CCP may include the following tasks to be performed by the respite service:
 - Bathing – Giving a sponge bath/bed bath/tub bath/shower, including transfer in/out;
 - Dressing – Putting on, fastening, removing clothing; including prosthesis;
 - Grooming – Shampooing, combing or brushing hair, applying makeup, trimming beard or mustache, braiding hair, shaving under arms or legs as requested by the member;
 - Oral care – Brushing teeth, cleaning dentures/partials (includes use of floss, swabs, or mouthwash). Members whose swallowing reflex is not intact, are an exception and may require specialized oral care beyond the scope of this service as identified by a physician’s order;
 - 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;
 - Perineal Care – Cleansing of the perineal area and changing of sanitary napkins;
 - Toileting – Transferring on/off toilet, bedside commode and/or bedpan; cleaning perinea area, changing adult briefs/pads, readjusting clothing;
 - 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

program for the member. An RN 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);

- 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. An RN 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);
- Mobility Assistance – Assistance in ambulation, transfer and toileting, defined as follows:
 - 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;
 - Transferring – Moving to/from one location/position to another with or without assistive device(s); and/or
 - Toileting – Transferring on or off toilet.
- Skin Care – Observation of skin condition for maintaining good skin integrity and prevention of skin infection, irritation, ulceration or pressure sores;
- 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 private duty nursing service standards;
- 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;

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

- 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;
- 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 IADLs and are provided as determined in the Care Plan;
- Shopping and/or completing errands for the member, with or without the member; and
- Accompanying or assisting with non-medical transportation.

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 assesses 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.

- **Service Requirements:**
 - Respite services are available to any member of any age;
 - Respite services are determined by MCO Care Coordinator and documented on the CCP; and
 - Respite services may be provided in the member’s home, in the respite provider’s home, and in the community.
- **Administrative Requirements:**
 - Respite agencies may be licensed by the DOH as an HH agency pursuant to 7.28.2.1 NMAC et seq.;
 - Respite services may be provided by agencies approved by HSD/MAD;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Respite agencies must comply with DOH abuse registry screening laws regulations in accordance with the DOH Act, NMSA 1978, section 90706(E) and the Employee Abuse Registry Act, NMSA 1978, Sections 24-27-1 to 24-27-8;
- 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;
- Respite agencies must comply with all requirements set forth in the Medicaid PPA;
- 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 backup plan that ensures the member’s health and safety;
- 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;
- Training of the bowel and bladder care must be taught by an RN 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;
- Respite supervisors must provide specific instructions to assigned respite staff on each member prior to providing services to the member. It is the responsibility of the respite agency to ensure that respite caregivers are appropriately trained; and
- Respite agencies must ensure written notification to the MCO and provide the MCO with a copy of the incident report.

Reimbursement

Respite provider agencies must maintain appropriate record keeping of services provided personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly rate and is accrued and rounded to the nearest quarter of an hour. Reimbursement for respite services will be based on the negotiated rate with the MCOs. Providers of respite services have the responsibility to review and ensure 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Limits or Exclusions

Respite services may not be provided to the member by his or her spouse. Respite services cannot be included in the CCP in combination with Assisted Living. Respite services and nursing respite services are limited to a total maximum of 300 hours per CCP year. Additional hours may be requested if an eligible member’s health and safety needs exceed the specified amount.

Authorization of Respite Services

Scheduling of hours for use of respite services will be the responsibility of the member or their representative. The provider agency may require advanced notice from the member/family for provision of services and will notify members of their advanced notice requirement. The provider of respite services must maintain a cumulative record of utilization of respite care, to include time used.

The member cannot schedule his or her own respite with the respite staff. The member may receive a maximum of 300 hours annually unless additional hours are approved by the MCO per Care Plan year.

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.

	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	--	---

8.18. Skilled Maintenance Therapies

Skilled maintenance therapies include OT, PT and speech and language therapy (SLT) for individuals 21 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.

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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.19. Occupational Therapy for Adults

OT is a skilled therapy service for individuals 21 years and older provided by a licensed occupational therapist. OT services promote/maintain fine motor skills, coordination, sensory integration, and/or facilitate the use of adaptive equipment or other assistive technology. A signed OT referral for treatment must be obtained from the member's PCP 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 EPSDT). Specific services may include the following scope of services:

Scope of Services

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

Service Requirements

- 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:
 - Obtaining pertinent medical history;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Assessing the member for specific needs in gross/fine motor skills pertinent to OT;
- Adapting the member's environment in order to meet his/her needs;
- Evaluating, administrating and interpreting tests;
- 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;
- Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response;
- Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation;
 - 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;
 - 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;
 - Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
 - Implement and administer appropriate treatment;
- Providing the member or caregiver education and documenting in the member's medical record;
- 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;

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 8: Agency-Based Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	--	--

- The staff: client rate is 1:1 for the period of time in which a specific member is receiving therapy services; and/or
- Therapy services may be provided at:
 - A community based center, i.e. therapy center;
 - The member's home; and/or
 - Any other location in which the member engages in day-to-day activities.
- 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.

Agency Provider Requirements

- Staffing Requirements:
 - Graduation from an accredited OT program and current licensure as required by New Mexico State law;
 - Must have a current licensure by State of New Mexico;
 - OT experience preferably in-home care and general acute care;
 - Must have access to all required diagnostic and therapeutic materials to provide services;
 - 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;
 - 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; and
 - Certified Occupational Therapy Assistants (COTA) may perform OT procedures and related tasks pursuant to a POC written by the supervising licensed occupational therapist. A COTA must be supervised by a licensed occupational therapist. All related

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

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.

- Administrative Requirements:
 - Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
 - Provider agencies will establish and maintain financial reporting and accounting for each individual;
 - All services must be under the order of the member’s PCP. The order will be obtained by the skilled therapist, and shared with the Care Coordinator; and
 - Therapy reports must be current and available upon request of HSD/MAD.

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 OT, 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.

- Payment for OT services through the MCO is considered payment in full.
- OT services must abide by all Federal, State, HSD policies and procedures regarding billable and non-billable items.
- Billable hours are as follows:
 - Face-to-face activities described in the Scope of Service;
 - Maximum of eight hours for an initial comprehensive individual assessment;
 - Maximum of eight hours to develop an initial comprehensive therapy plan;
 - Attendance and/or telephone conference call to participate in IDT meetings;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

- Annual maximum of six hours to complete progress reports and/or to revise annual plan;
 - Annual maximum of eight hours to arrange assistive technology development;
 - Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour; and
 - Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- The MCO does not consider the following to be professional OT services and will not authorize payment for the following non-billable activities:
 - Performing specific errands for the individual and/or family that are not program specific;
 - Friendly visiting;
 - Financial brokerage services, handling of member finances, or, preparation of legal documents;
 - Time spent on paperwork or travel that is administrative for the provider;
 - Transportation of members;
 - Pick up and/or delivery of commodities; and
 - Other non-Medicaid reimbursable activities.
 - OT services are provided with the understanding that the MCO is the payer of last resort. OT 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.
 - OT providers must ensure all insurance records are maintained correctly.
 - Reimbursement for OT services will be based the negotiated rates with the MCO. Providers of service have the responsibility to review and ensure 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.20. Physical Therapy for Adults

PT is a skilled therapy service for members 21 years and older provided by licensed Physical therapist. PT services promote/maintain gross/fine motor skills, facilitate independent functioning and/or prevent progressive disabilities. A signed PT referral for treatment must be obtained from the member’s PCP 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 EPSDT. Specific services may include the following;

Scope of Services

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

Service Requirements

- 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:
 - Obtaining pertinent medical history;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Assessing of the member on physical strengths and deficits including, but limited to:
 - Range of motion for all joints;
 - Muscle strength, gait pattern, sensation, balance, coordination, and perception;
 - Skin integrity and respiratory status;
- Functional level of motor developmental level;
- Adapting the member's environment in order to meet his/her needs;
- Evaluating, including the administration and interpreting tests and measurements within the scope of the practitioner;
- 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;
- Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response;
- Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation;
- 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. 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;
- Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
- Implement and administer appropriate treatment;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Providing the member or caregiver education and documenting in the member's medical record; and
- 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.
- The staff to client rate is 1:1 for the period of time in which a specific member is receiving therapy services; and/or
 - Therapy services may be provided at:
 - A community based center (i.e., therapy center);
 - The member's home; and/or
 - Any other location in which the member engages in day-to-day activities.
- 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.

Agency Provider Requirements

- Staffing Requirements:
 - Graduation from an accredited PT program and current licensure as required by New Mexico State law:
 - Must have a current licensure by State of New Mexico;
 - PT experience preferably in-home care and general acute care;
 - Must have access to all required diagnostic and therapeutic materials to provide services;
 - 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;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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; and
 - Certified Physical Therapy Assistants (PTA) may perform PT procedures and related tasks pursuant to a POC 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.
- Administrative Requirements:
 - Provider agencies must adhere to HSD/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
 - All services must be under the order of member's PCP. The order will be obtained by the skilled therapist, and shared with the MCO Care Coordinator; and
 - Therapy reports must be current and available upon request of HSD/MAD.

Reimbursement

Each provider of PT services is responsible to provide clinical documentation that identifies his or her role in all components of the provision of PT, 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.

- Payment for PT services through the MCO is considered payment in full.
- PT services must abide by all Federal, State, HSD policies and procedures regarding billable and non-billable items.
- Billable hours are as follows:
 - Face-to-face activities described in the Scope of Service;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Maximum of eight hours for an initial comprehensive individual assessment;
- Maximum of eight hours to develop an initial comprehensive therapy plan;
 - Attendance and/or telephone conference call to participate in IDT meetings;
 - Annual maximum of six hours to complete progress reports and/or to revise annual plan;
 - Annual maximum of eight hours to arrange assistive technology development;
 - Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour;
 - Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable;
- The MCO does not consider the following to be professional PT services and will not authorize payment for the following non-billable activities:
 - Performing specific errands for the individual and/or family that are not program specific;
 - Friendly visiting;
 - Financial brokerage services, handling of member finances, or, preparation of legal documents;
 - Time spent on paperwork or travel that is administrative for the provider;
 - Transportation of members;
 - Pick up and/or delivery of commodities; and
 - Other non-Medicaid reimbursable activities.
- PT services are provided with the understanding the MCO is the payer of last resort. PT 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;
- PT providers must ensure all insurance records are maintained correctly; and

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- Reimbursement for PT 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.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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8.21. Speech Therapy for Adults

SLT is a skilled therapy service for individuals 21 years and older provided by a licensed speech and language pathologist. SLT 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 PCP 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 EPSDT. Specific services may include the following;

Scope of Services

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

Service Requirements



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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:
 - Obtaining pertinent medical history;
 - Assessing for speech language disorders;
 - Assessing for swallowing disorders (dysphasia);
 - 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);
 - Assessing of oral motor function;
 - Assessing for the use of prosthetic/adaptive devices;
 - Assessing of resonance and nasal airflow;
 - Assessing of orofacial myofunctional patterns;
 - 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;
 - Administering a technically complete and correct program, using skilled techniques, that provides for flexibility to member response;
 - Establishing individualized service goals and formulate a treatment plan on the basis of the member evaluation;
 - 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 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.;



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
- Review physician's request for treatment, and if appropriate, recommend revisions on the basis of evaluative findings;
- Implement and administer appropriate treatment;
- Providing the member or caregiver education and documenting in the member's medical record;
- 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;
- The staff to client rate is 1:1 for the period of time in which a specific member is receiving therapy services; and
- Therapy services may be provided at:
 - A community based center (i.e., therapy center);
 - The member's home; and/or
 - Any other location in which the member engages in day-to-day activities.
- 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.

Agency Provider Requirements

- Staffing Requirements:
 - Graduation from an accredited masters or doctoral degree level, and holding the Certificate of Clinical Competence from the American Speech Language Hearing Association;
 - Must have a current licensure by State of New Mexico;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- SLT experience preferably in home care and general acute care;
- Must have access to all required diagnostic and therapeutic materials to provide services;
- 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; and
- 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.
- Administrative Requirements:
 - Provider agencies must adhere to the HSD/MAD requirements including but not limited to: OSHA training requirements, incident management reporting, CBC, labor laws, etc.;
 - Provider agencies will establish and maintain financial reporting and accounting for each individual;
 - All services must be under the order of the member's PCP. The order will be obtained by the skilled therapist, and shared with the MCO; and
 - Therapy reports must be current and available upon request of HSD/MAD.

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.

- Payment for SLT services through the MCO is considered payment in full.

	<p>Section 8: Agency-Based Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- SLT services must abide by all Federal, State, HSD policies and procedures regarding billable and non-billable items.
- Billable hours are as follows:
 - Face-to-face activities described in the Scope of Service;
 - Maximum of eight hours for an initial comprehensive individual assessment;
 - Maximum of eight hours to develop an initial comprehensive therapy plan;
 - Attendance and/or telephone conference call to participate in IDT meetings;
 - Annual maximum of six hours to complete progress reports and/or to revise annual plan;
 - Annual maximum of eight hours to arrange assistive technology development;
 - Reimbursement is on a unit rate per hour and rounded to the nearest quarter hour; and
 - Training on member specific issues is reimbursable, general training requirements are an administrative cost and not billable.
- HSD/MAD does not consider the following to be professional SLT services and will not authorize payment for the following non-billable activities:
 - Performing specific errands for the individual and/or family that are not program specific;
 - Friendly visiting;
 - Financial brokerage services, handling of member finances, or, preparation of legal documents;
 - Time spent on paperwork or travel that is administrative for the provider;
 - Transportation of members;
 - Pick up and/or delivery of commodities; and
 - Other non-Medicaid reimbursable activities.
- SLT 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



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

reimbursement through third party liability or other payment sources, these sources must be accessed before ABCB services are delivered.

- SLT providers must ensure all insurance records are maintained correctly.
- Reimbursement for SLT 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.

Services, Service Codes and Applicable Units of Service

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Adult Day Health	S5100	15 minutes
Assisted Living	T2031	Day
Community Transition Services	T2038	Per service
Emergency Response	S5161	Month
Emergency Response High Need	S5161 U1	Month
Environmental Modifications	S5165	1 unit per project
Behavior Support Consultation	H2019	15 minutes
Behavior Support Consultation, Clinic Based	H2019TT	15 minutes
Employment Supports	H2024	Day
Home Health Aide	S9122	Hour
Nutritional Counseling	S9470	Hour
Personal Care-Consumer Directed	99509	Hour
Personal Care-Consumer Delegated	T1019	15 minutes
Personal Care-Directed training	S5110	15 minutes
Personal Care-Directed-Administrative Fee	G9006	1 unit + 1 month
Personal Care-Directed Advertisement Reimbursement Fee	G9012	1 Advertisement



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SERVICE TYPE	CODE	UNIT INCREMENTS 1 UNIT =
Private Duty Nursing for Adults – RN	T1002	15 minutes
Private Duty Nursing for Adults – LPN	T1003	15 minutes
Respite RN	T1002 U1	15 minutes
Private Duty Nursing for Adults – LPN	T1003 U1	15 min
Respite	99509 U1	Hour
Physical Therapy for Adults	G0151	15 minutes
Occupational Therapy for Adults	G0152	15 minutes
Speech Language Therapy for Adults	G0153	15 minutes

Personal Care Services (PCS) Consumer Directed Model Code Definitions

Personal Care Consumer-Directed	99509	Hour	The rate for ongoing attendant services. The rate includes both the employee's and the employer's share of Social Security withholding and the cost for worker's compensation insurance. The maximum number of hours billable is determined by the authorization issued by the MCO which must be approved by the MCO Medicaid Utilization Review Department.
Personal Care Consumer-Directed Training	S5110	15 minutes	The rate for training provided to the consumer or their attendant at the request of the consumer. There is an annual maximum of eight (8) hours of training allowed per consumer.
Personal Care Consumer-Directed Advertisement Reimbursement Fee	G9012	1 unit = 1 advertisement	The maximum allowable rate for advertising. Consumers are reimbursed for up to two (2) advertisements per year if seeking a new Personal Care Attendant. If the billed amount exceeds the maximum allowable rate, the billed amount will be reduced to the maximum allowable rate. The advertising reimbursement is allowed only for actual and necessary advertising. Documentation is required in the case file.



Section 8: Agency-Based Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Personal Care Consumer-Directed Administrative Fee	G9006	1 unit = 1 month	The rate for fiscal intermediary tasks such as processing payroll for the consumer's Personal Care Attendants, producing reports required by the Medical Assistance Division, processing claims for Consumer-Directed Personal Care services (including Income Tax and Social Security withholding) and submitting billings to the MCO.
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	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9. Self-Directed Community Benefits

9.1. Purpose

The SDCB is intended to provide a community-based alternative to institutional care that facilitates greater member choice, direction and control over covered services and supports. For this section of the Manual, the terms “member”, “care plan”, “services” and “providers” refer to SDCB.

HCBS shall meet the following standards:

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

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.2. Guiding Principles

All members:

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

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

9.3. Philosophy of Self Direction

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

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.4. Definitions

1. **Authorized Representative (AR):** The AR is an individual designated to represent and act on the member's behalf. The member or AR must provide formal documentation authorizing the named individual or individuals to access the identified case information for a specified purpose and time frame. An AR 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.
2. **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.
3. **Electronic Visit Verification (EVV):** EVV is a computer-based system that electronically verifies the occurrence of authorized personal care service visits by electronically documenting the precise time and location where a service delivery visit begins and ends. For SDCB, EVV will be implemented according to federal requirements and timelines.
4. **Employer of Record (EOR):** Individual responsible for directing the work of SDCB employees by recruiting, hiring, training, supervising and terminating employees, and ensuring payment to employees and vendors.
5. **Financial Management Agency (FMA):** Contracted with each Centennial Care MCO and helps the member implement the approved SDCB Care Plan by receiving and processing payment requests for the member's employees and vendors, tracking the SDCB expenditures and credentialing the SDCB employees and vendors.
6. **FOCoSonline:** The web-based system used by the SDCB FMA for receiving and processing SDCB payment requests. The FOCOsonline system is also used by members, Care Coordinators, and Support Brokers to develop and submit SDCB care plan/budget requests for MCO/UR review, and to monitor utilization and spending throughout the SDCB care plan year.
7. **Human Services Department (HSD):** Designated by CMS as the Medicaid administering agency in New Mexico. HSD is also responsible for operating the SDCB HCBS for populations that meet the NF LOC (disabled & elderly, brain injury, and AIDS).

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

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 member. Payment may not be made to a LRI for the provision of personal care or similar services that the LRI would ordinarily perform or be responsible to perform on behalf of a 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. **MCO/UR:** Provides services related to medical eligibility determination and re-determination, and NF LOC for members. The MCO also performs UM duties, review and approval or denial of each individual services or related goods requested in the SDCB care plan/budget.
10. **Quality Assurance and Quality Improvement (QA/QI):** Processes utilized by state and Federal governments, programs and providers whereby appropriate oversight and monitoring of CBs 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 QI.
11. **Reconsideration:** Members who disagree with an adverse decision made by the MCO/UR may submit a written request through a Care Coordinator/Support Broker to the MCO/UR for a reconsideration of the adverse decision. These requests must include new, additional information that is different from, or expands on, the information submitted with the initial request.
12. **SDCB:** Is a component of the State's 1115 (c) Medicaid Managed Care waiver which allows eligible members meeting NF LOC the option to access SDCB Medicaid funds, using the essential elements of person-centered planning, individualized budgeting, member protections, and QA/QI. Members have choices (among the state-determined SDCB services and related goods) in identifying, accessing and managing the services and related goods needed to meet their personal goals.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- 13. SDCB Budget:** The maximum budget allotment available to an eligible member, determined by his/her established NF LOC, CNA, and the amount and type of services the member was receiving in the ABCB. Based on this maximum amount, the eligible member will develop a SDCB care plan to meet his/her assessed functional, medical and habilitative needs to enable that member to remain in the community.
- 14. SDCB Care Plan:** A plan that includes approved SDCB services of the SDCB member's choice; the projected cost, frequency and duration of services and related goods; the type of provider who will furnish each service or related good; other services and related goods to be used by the member. Each SDCB care plan shall include a backup plan which lists who the member will contact if regularly scheduled employees or service providers are unable to report to work. The SDCB care plan is mandatory for all SDCB members and must be processed through the FOC*o*Online system.
- 15. SDCB Member:** An individual who meets the medical and financial eligibility and is approved to receive services through the SDCB after receiving services in the ABCB for a minimum of 120 calendar days.
- 16. Support Broker (SB):** An individual who provides support to members and assists the member (or the member's family or representative, as appropriate) in arranging for, directing and managing services and supports as well as developing, implementing and monitoring the SDCB care plan and budget. Individual Support Brokers work for MCO contracted Support Broker agencies or may be directly employed by a MCO.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.5. SDCB Member Rights

SDCB member has the right to:

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

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.6. SDCB Member Responsibilities

SDCB members have certain responsibilities in order to participate in the program. Failure to comply with these responsibilities or other program rules and policies can result in an involuntary termination from the SDCB.

The most basic responsibility of each member is to maintain his/her financial and medical eligibility to remain in the SDCB. This includes completing the required documentation to determine initial and annual financial eligibility and participating in the initial and annual CNA conducted by the MCO. The Care Coordinator and Support Broker may assist with the application and recertification process as needed.

Ongoing SDCB member responsibilities include:

- Comply with the rules and policies that govern the SDCB;
- 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;
- 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 months. Report concerns or problems with any part of SDCB to the Support Broker or Care Coordinator;
- Use SDCB funds appropriately by only requesting services and related goods covered by the SDCB and only purchasing services and related goods after they have been approved by the MCO;
- Comply with the approved SDCB care plan and not spend more than the authorized budget;
- Work with the Care Coordinator by attending scheduled meetings and assessments, in the member's home as required, and providing documentation as requested;
- Respond to requests for additional documentation and information from the Care Coordinator, Support Broker, FMA, and the MCO within the required deadlines;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Report to the local ISD office, within 10 business days, any change in circumstances, including, but not limited to, a change in address or hospitalization, which may affect eligibility for the program. Changes in address or other contact information must also be reported to the Care Coordinator, Support Broker and the FMA within 10 calendar days;
- Report to the Care Coordinator and Support Broker if hospitalized for more than three consecutive nights so that a new appropriate LOC or CNA can be conducted; and
- Communicate with SDCB service providers, State contractors and State personnel in a respectful, non-abusive and non-threatening manner.

Member/employer of record (EOR) Responsibilities: Every member must have an EOR who is responsible for directing the work of SDCB employees, and ensuring accurate and timely employee and vendor payment requests are sent to the FMA for processing. The EOR must authorize by signing, either electronically or on paper, all invoices and timesheets for his/her 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 designated EOR may not be an employee of the member. Members may also designate an individual of their choice to serve as their EOR, subject to the EOR meeting the qualifications specified in the SDCB rules and policies. The Care Coordinator completes an EOR self-assessment at least annually with the member to determine if the member requires assistance in fulfilling the EOR responsibilities. If the EOR self-assessment demonstrates the member is not able to be his/her own EOR, and the member does not designate a qualified individual to serve as the EOR, the member shall not be allowed to transfer to SDCB until the member designates a suitable EOR. If the member was already his/her own EOR, and based on the results of the self-assessment, the Care Coordinator determines that the member requires assistance to direct his or her services, the Care Coordinator shall inform the member that he or she will need to designate an EOR to assume the self-direction functions on their behalf. A member's failure to follow this direction may be cause for involuntary termination from the SDCB program.

An EOR is responsible for recruiting, hiring, training, supervising and terminating employees, as necessary. The EOR will establish work schedules and tasks and provide relevant training. The EOR will keep track of SDCB budget amounts spent on paying employees and for approved services and related goods. EORs authorize the payment of timesheets and invoices by the

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

FMA. In accordance with the State’s timeline for implementation of EVV to ensure compliance with the 21st Century Cures Act, EORs must use the FMA electronic timesheet system, unless granted an exception by the MCO. EORs must also ensure that their self-directed personal care provider(s) uses the State approved EVV system as required. An EOR cannot be paid for any services utilized by the member for whom he or she is the EOR and the EOR cannot be paid for performing the EOR functions. An individual may serve as an EOR for more than one SDCB member.

The SDCB member/EOR responsibilities include:

- Arranging for the delivery of SDCB services, supports and related goods as approved in the SDCB care plan;
- Verifying and attesting that employees meet the minimum qualifications for employment as required by the SDCB;
- Orienting, training, and directing SDCB employees in providing the services that are described and authorized in the member’s SDCB care plan;
- 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;
- 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, CBC forms, time-sheets, payment request forms (PRFs) and invoices, updated employee information, and other documentation needed by the FMA to process timely and accurate payment to SDCB providers;
- Agreeing that SDCB employees may not begin work until all materials necessary for a CBC have been received by the FMA and the employee has successfully passed the COR background check and the National Sex Offender Registry;
- Agreeing to select or employ the employee on an interim (temporary) basis until a final CBC has been successfully completed, for those crimes determined to be disqualifying

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

convictions as stated in NMSA 1978, Section 29-17-3. The EOR discusses this with the employee and reserves the right to dismiss the employee based on the results of the CBC;

- Providing fair notice of changes in the employee’s work schedule in the event of unforeseen circumstances or emergencies;
- Review and approve/deny completed employee timesheets in order to pay employees according to the FMA predetermined payroll schedule. Net wages are gross earnings calculated according to the employee’s pay rate, minus payroll deductions for the employee’s share of applicable State, Federal, and local payroll withholdings;
- Ensure employees are not signing or sending in their own timesheets;
- Reporting any incidents of abuse, neglect or exploitation by any employee or other service provider to the Support Broker and/or Care Coordinator;
- Maintaining SDCB employee and service records and documentation in accordance with SDCB rules and policies, and Federal and state employment rules;
- As the common-law employer, fully cooperating with the New Mexico Department of Workforce Solutions (DWS) in any investigations or other matters related to his/her SDCB employees;
- Work with the FMA and Care Coordinator on payment issues;
- Fully cooperating with the State’s worker’s compensation carrier. Responsibilities include reporting claims and providing information to New Mexico Mutual;
- Meeting Federal employer requirements, such as completing and maintaining a Federal I-9 form for each employee as required by law; and
- When necessary, requesting assistance from the Support Broker and/or Care Coordinator with any of these SDCB responsibilities.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.7. SDCB Supports

Important resources of support and direction for members are the MCO, the Support Broker and the FMA. The MCO determines initial and ongoing medical eligibility, reviews and authorizes the SDCB care plan/budget, and provides care coordination and support to the member to ensure successful implementation of the 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 care plan and budget. The FMA acts as the intermediary between the member and the Medicaid payment system and assists the member or the EOR with employer-related responsibilities.

MCO

The MCO provides services related to medical eligibility determination and re-determination, and determines the NF LOC for SDCB members. The MCO also performs UM duties, including review and approval or denial of each individual care plan. All SDCB members have a MCO Care Coordinator and a Support Broker. The Care Coordinator and Support Broker assist the 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.

Care Coordinator

The Care Coordinator is responsible for managing the member’s acute care, BH care, LTC, and HCBS. In SDCB, the Care Coordinator is primarily responsible for coordinating all aspects of the member’s care and for determining the SDCB budget, and submitting the care plan to the MCO for review and approval/denial. Care Coordinator related assistance includes, but is not limited to:

- Understanding SDCB member and EOR roles and responsibilities;
- Identifying resources outside the SDCB, including natural and informal supports, that may assist in meeting the member’s needs;
- Understanding the array of SDCB covered services, supports, and related goods;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- 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 Agreement and the member’s CB;
- Providing the Support Broker with the current and all historical CNAs including the assessor’s individual specific health and safety recommendations, and the calculations used to determine the SDCB budget;
- Monitoring utilization of SDCB services and related goods on a regular basis;
- Assisting the EOR, and working with the FMA; on payment issues;
- Conducting employer-related activities such as completing the EOR self-assessment with the member and informing the FMA of the designated EOR;
- Identifying and resolving issues related to the implementation of the SDCB care plan/budget;
- Assisting the SDCB member with QA activities to ensure implementation of the member’s SDCB care plan/budget, and utilization of the authorized budget;
- Recognizing and reporting critical incidents, including abuse, neglect, exploitation, emergency services, law enforcement involvement, and environmental hazards;
- Monitoring quality of services provided by Support Brokers;
- Assisting the member with Support Broker changes; and
- Working with the member to provide the necessary assistance for successful SDCB implementation.

Support Broker

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

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

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

- The extent of assistance is based upon the individual member's needs, and includes, but is not limited to, providing help and guidance to:
 - Educate members on how to use self-directed supports and services and provide information on program changes or updates;
 - Review, monitor and document progress of the member's care plan;
 - Assist in managing budget expenditures and complete and submit care plan revisions;
 - Assist with EOR functions including, but not limited to recruiting, hiring and supervising SDCB providers;
 - Assist with developing job descriptions for the SDCB direct support caregivers;
 - Assist with completing forms related to SDCB employees;
 - Assist with approving timesheets and purchase orders or invoices for related goods, obtaining quotes for services and related goods as well as identifying and negotiating with vendors;
 - Assist with problem solving employee and vendor payment issues with the FMA and other relevant parties;
 - Facilitate resolution of any disputes regarding payment to providers for services rendered;
 - Develop the care plan based on the SDCB budget amount determined by the annual CNA; and
 - Assist in completing all documentation required by the FMA.
- Support Broker services begin with the enrollment of the member in SDCB and continue throughout the member's participation in SDCB. The Support Broker shall:



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Conduct a transition meeting, including the transfer of program information prior to the SDCB enrollment meeting, for those members transitioning from the ABCB;
- Assist members to transition from/to ABCB/SDCB.
- Provide the SDCB member with information, support and assistance during the annual Medicaid eligibility processes, including the annual CNA and the annual medical/financial eligibility processes;
- Assist existing members with annual LOC requirements within 120 calendar days prior to the expiration of the LOC; and
- Schedule member enrollment meetings within five 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:
 - Ensure the member has received and reviewed the SDCB Rules and the Manual and provide responses to their questions and/or concerns;
 - General overview of the SDCB including key agencies, their responsibilities and contact information;
 - Discuss the annual Medicaid eligibility requirements and offer assistance in completing these requirements as needed;
 - Discuss and review SDCB member roles and responsibilities;
 - Discuss and review the EOR roles and responsibilities;
 - Discuss and review the processes for hiring SDCB employees and contractors and required paperwork;
 - Discuss and review the requirements, process and paperwork for hiring LRIs as employees;
 - Discuss and review the background check and other credentialing requirements for SDCB employees and vendors;
 - Referral for accessing training for the FOC*o*Online system; and to obtain information on the FMA;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Discuss and review the EVV system that personal care provider(s) will be required to use;
- Schedule the date for SDCB care plan meeting within 10 business days of the SDCB enrollment meeting;
- Provide information on the SDCB care plan including covered services and related goods, and community resources available;
- Assist the members in utilizing all program assessments including CNA, to develop each SDCB care plan;
- Educate members regarding SDCB covered services, supports and related goods;
- Assist member to identify resources outside SDCB that may assist in meeting his/her needs as identified in the CNA;
- Assist the member with the application for LRI as employee process; submit the application to the MCO/UR;
- Assist members with the environmental modification process;
- Serve as an advocate for the SDCB member, as needed, to enhance his/her opportunity to be successful in the SDCB;
- Assist the member with reconsiderations of services or related goods denied by the MCO/UR, submit documentations as required, and participate in MCO appeals process and State Fair Hearings as requested by the MCO, SDCB member or state;
- Assist the member with QA activities to ensure implementation of the member's SDCB care plan, and utilization of the SDCB annual budget;
- Assist members to transition to another Support Broker agency when requested. Support Broker transitions should occur within 30 calendar days of SDCB member's written request, but may occur sooner based on the needs of the SDCB member. Transition from one Support Broker agency to another can only occur at the first of the month. Support Broker agency transitions may not occur if there are less than 120 days remaining in the current LOC; and

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

- Assist members to identify and resolve issues related to the implementation of the SDCB care plan.
- Support Brokers must ensure the SDCB care plan for each member is submitted in the appropriate format as prescribed by the state and MCOs, utilizing the FOCo*Online* system. The care plan in FOCo*Online* shall include the following:
 - The requested services and supports that are covered by the SDCB, and necessary to address the needs of the member as determined through the CNA and person-centered planning process;
 - The purpose for the requested services, expected outcomes, and methods for monitoring progress must be clearly and specifically identified and addressed;
 - Clear, specific and accurate calculation of the employee/vendor reimbursement rate including all local and/or Federal taxes using the calculator in FOCo*Online*; and
 - The quality indicators, identified by the member, for the services and supports provided through the SDCB. SDCB care plan revisions shall be completed and submitted as needed, in the format as prescribed by the state. No more than one revision is allowed to be submitted at any given time. The annual SDCB care plan must be submitted to the Care Coordinator and MCO/UR at least 30 calendar days prior to the expiration of the current SDCB plan so that sufficient time is afforded for MCO/UR review. A copy of the final approved SDCB care plan and budget documents must be provided to each SDCB member.
- Support Brokers will contact the SDCB member in person or by telephone at least monthly for a routine follow-up. Support Brokers will meet in person with the member at least once per quarter. It is mandatory that a minimum of one visit per SDCB care plan year is to be conducted in the member's home. Support Brokers will, at a minimum:
 - Review spending patterns;
 - Review and document progress of care plan/budget implementation;
 - Document the usage and effectiveness of the SDCB backup plan; and
 - Document the purchase of related goods.

The quarterly visits are for the following purposes:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

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

Administrative Requirements

Support Broker services may be provided by direct MCO personnel or by Support Broker agencies subcontracted by the MCO. SDCB members may choose to work with one of their MCO’s contracted Support Broker agencies that is providing Support Broker services in their region. If an MCO employs MCO personnel to provide Support Broker services, the same qualifications and criteria that are used for Support Broker agencies also applies to the MCO personnel.

The Support Broker agency shall comply with all applicable Federal, State rules, all policies and procedures governing Support Broker services, all terms of their provider agreement and shall meet all of the following requirements, as applicable:

- Have a current business license issued by the state, county, or city government as required;
- Maintain financial solvency;
- 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;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- Ensure all employees are trained and competent in the use of the FMA and FOCo*Online* system;
- 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
- Ensure compliance with the Caregivers Criminal History Screening Requirements (7.1.9 NMAC) for all employees.
- The Support Broker agency shall develop a quality management plan to ensure compliance with regulatory and program requirements and to identify opportunities for continuous QI.

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:

- The Support Broker agency must maintain a presence in each region for which they are providing services;
- 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;
- 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;
- 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 ADA;
- The Support Broker agency must maintain an operational fax machine at all times;
- The Support Broker agency must maintain an operational email; address, internet access, and the necessary technology to access SDCB related systems;
- The Support Broker agency shall maintain a current local/state community resource manual;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

- The Support Broker agency shall adhere to Medicaid General Provider policies 8.302.1.;
- The Support Broker agency shall ensure the development and implementation of a written grievance procedure in compliance with 8.349.2.11 NMAC;
- The Support Broker agency shall meet all of the qualifications set forth in 8.304.12 NMAC; and/or
- The Support Broker agency shall maintain HIPAA compliant primary records for each member including, but not limited to:
 - Current and historical SDCB care plan and budget;
 - Contact log that documents all communication with the SDCB member;
 - Completed/signed quarterly visit form(s);
 - MCO/UR documentation of approvals/denials, including SDCB care plan and revision requests;
 - MCO/UR correspondence; (requests for additional information, etc.);
 - Copy of current and all historical CNA including the assessor’s individual specific health and safety recommendations;
 - Notifications of medical and financial eligibility;
 - SDCB budget utilization reports from the FMA;
 - Environmental modification approvals/denials;
 - LRI approvals/denials;
 - Documentation of SDCB member and employee incident management training;
 - Copy of legal guardianship or representative papers and other pertinent legal designations;
 - Copy of the approval form for the AR and/or AA; and/or
 - Copies of completed EOR self-assessments.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

Support Broker Qualifications

Support Broker agencies shall ensure that all individuals providing Support Broker services meet the criteria specified in this section. Support Broker providers shall:

- Be at least 18 years of age;
- Possess a minimum of a Bachelor’s degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; and
- Have one year of supervised experience working with seniors and/or people living with disabilities;
- Have a minimum of six years of direct experience related to the delivery of social services to seniors and/or people living with disabilities;
- Complete all required SDCB orientation and training courses; and/or
- 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; and the National Sex Offender Registry.

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.

Critical Incident Management Responsibilities and Reporting Requirements

All incident reports for the HCBS and BH services population involving abuse, neglect, self-neglect, exploitation, environmental hazard, law enforcement involvement, and emergency services, must be reported to the member’s MCO, Support Broker and/or APS.

The Support Broker agency shall provide training to SDCB members related to recognizing and reporting critical incidents. Critical incidents include: abuse, neglect, exploitation, emergency services, law enforcement involvement, environmental hazards and member deaths. This SDCB member training shall also include reporting procedures for SDCB employees,

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

members/member representatives, and other designated individuals. Please refer to the Critical Incident Management Responsibilities for requirements.

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. The Support Broker agency shall report incidents of abuse, neglect and/or exploitation as directed by the State.

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.

Financial Management Agent

The FMA is under contract with the MCOs to provide payment for services and related goods which are approved on the SDCB care plan. The FMA is responsible for providing the following services in the SDCB:

- Assure SDCB compliance with state and Federal employment and IRS requirements;
- Assist each member/EOR to set up a unique EIN if they intend to hire employees;
- Answer member inquiries, solve related problems, and offer periodic trainings for members and their representatives on how to handle the SDCB billing and invoicing processes;
- Provide all members with necessary documents, instructions and guidelines;
- Collect all documentation necessary to verify that SDCB providers and vendors have the qualifications and credentials required by the SDCB rules;
- Collect all documentation necessary to support the member's specific arrangements with each employee and vendor, including employment agreement forms and vendor agreement forms;
- 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 and the National Sex Offender Registry;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- Check the Department of Health Employee Abuse Registry, pursuant to 7.1.12 NMAC COR, to determine whether prospective SDCB service providers or employees of members are included in the registry. If a prospective SDCB provider or employee is listed in the Abuse Registry, that person or vendor may not be employed by a SDCB member/EOR;
- Process and pay invoices for services and related goods that are approved in the member's care plan, when supported by required documentation;
- Handle all payroll functions on behalf of 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;
- Track and report on SDCB employee payment disbursements and balances of member funds, including providing the member and his/her Care Coordinator/Support Broker with a monthly report of expenditures and budget status; and
- Report any concerns related to the health and safety of a member or that the member is not following the approved SDCB care plan/budget to the Care Coordinator and/or Support Broker, and HSD/MAD, as appropriate.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

FOCoSonline

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

FOCoSonline is also used by SDCB members/EORs, Support Brokers and Care Coordinators to develop and submit a SDCB care plan for MCO/UR review and approval/denial.

The MCO/UR also uses *FOCoSonline* to receive SDCB care plan/budget requests and request additional information from the SDCB member and Care Coordinator/Support Broker, and to indicate what SDCB services, supports and related goods have been approved or denied.

The FMA will provide SDCB members/EORs, Care Coordinators and Support Brokers with training and access for *FOCoSonline*, as well as on-going technical assistance and help with problem solving.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

9.8. Planning and Budgeting for SDCB Covered Services

SDCB Care Plan Development Processes

The SDCB care plan development process starts with person-centered planning. In person-centered planning, the SDCB care plan must revolve around the individual SDCB member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the SDCB care plan development process is for the SDCB member to achieve a meaningful life in the community, as defined by the SDCB member. Upon enrollment in SDCB and choosing his/her Support Broker agency, each SDCB member shall receive a SDCB budget amount, which is determined by the Care Coordinator, based on the results of the NF LOC and the CNA. The SDCB budget amount is entered into FOCo*Online* 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 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 member desires, he/she may include family members or other individuals, including service workers or providers, in the SDCB care plan development process. The SDCB care plan is entered into FOCo*Online* by the Support Broker. The SDCB care plan is developed one goal at a time. Each goal shall include a clear and complete explanation of the requested service(s) or good(s) as defined in the service description, how they are related to the member's condition and why they are appropriate for the member.

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

The SDCB care plan is developed by the 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 FOCo*Online*, the member's SDCB care plan is ready for review and submission into FOCo*Online*. After reviewing the SDCB care plan, the Care Coordinator will submit it in FOCo*Online* to the MCO/UR for review and approval or denial using FOCo*Online*. Annual SDCB care plans shall be submitted by the Care Coordinator to the MCO/UR no later

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

than 30 calendar days prior to the end of the current SDCB care plan/budget year. MCOs must provide the member with a written Notice of Action for all MCO/UR decisions made in response to SDCB service related requests made by the SDCB member via FOCo*Online*.

SDCB Member’s Employer Authority

The SDCB EOR is the common-law employer of all SDCB service providers. The FMA serves as the member’s agent in conducting payroll and other employer-related responsibilities that are required by Federal and State law.

SDCB Member Decision-Making Authority

Members shall have authority to do the following:

- Complete the employer paperwork to be submitted to the FMA;
- Determine the amount paid for SDCB services within the State’s approved limits (Range of Rates, 9.A.);
- Schedule the provision of SDCB services;
- Specify service provider qualifications of the SDCB member’s choice, consistent with the qualifications specified in the SDCB rules and the Manual;
- Specify how SDCB services are provided, consistent with the SDCB rules and the Manual;
- Identify potential SDCB service providers and vendors and refer them to the FMA for enrollment;
- Arrange to have potential SDCB service providers paid for the approved SDCB services by ensuring that all proposed SDCB employees and service providers complete all FMA required paperwork, including a CBC when necessary. Payment for approved SDCB services and related goods cannot be made until all necessary and required paperwork is successfully completed and approved by the FMA;
- Review, approve and submit SDCB provider timesheets to the FMA within established timeframes. Timesheets must be submitted to the FMA electronically through FOCo*Online*. The member’s MCO shall approve an exception to the online timesheet requirement if the member is unable to submit timesheets electronically. Failure to submit SDCB provider

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

timesheets within the required timeframes will result in SDCB providers not being paid in accordance with the employee payroll schedule;

- Review, approve and submit payment requests, according to the SDCB care plan, for approved SDCB services and related goods identified in the approved SDCB care plan. The SDCB member/EOR must submit a PRF to the FMA and an invoice or receipt from a SDCB vendor for any item he/she has an approved SDCB goal and budget to purchase; and
- Additionally, the SDCB members:
 - Cannot/will not be reimbursed directly for any SDCB services, supports and/or related goods;
 - Must follow the SDCB care plan as approved by the MCO/UR;
 - 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
 - Shall be accountable for the use of all SDCB funds.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

9.9. 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 the Manual and submit an employee agreement packet or vendor agreement packet, specific to the SDCB provider or vendor type, for approval to the FMA.

SDCB providers must meet all Federal and State requirements for home- and community-based providers. In order to be an authorized provider for SDCB, and receive payment for delivered services, the potential provider must complete and sign an employee agreement or vendor agreement and provide all required credentialing documents. The potential provider's credentials must be verified by the member/EOR and the FMA.

General qualifications for SDCB individual employees, independent providers, including non-licensed homemaker/companion workers and provider agencies who are employed by a SDCB member/EOR to provide direct services:

- Be at least 18 years of age;
- Be qualified to perform the service and demonstrate capacity to perform required tasks;
- Be able to communicate successfully with the SDCB member;
- 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 and the National Sex Offender Registry;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- 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;
- Meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---	---

- Maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

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

- Be qualified to provide the service;
- Possess a valid business license, if applicable;
- 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;
- If a Support Broker provider, meet all of the qualifications set forth in 8.308.12 NMAC;
- If a currently approved SDCB provider, be in good standing with the appropriate state agency;
- Meet any other service specific qualifications, as specified in the SDCB rules (8.308.12 NMAC); and
- Maintain documentation of services provided per the SDCB rules (8.308.12 NMAC).

General qualifications for LRIs who provide services:

- LRIs (e.g., the parent/guardian biological, legal or adoptive) of a minor child (under age 18) or the guardian of a minor child, who must provide care to the child, or a spouse of a member, may be hired and paid for the provision of SDCB-covered services (except Support Broker) under extraordinary circumstances in order to assure the health and welfare of the member, to avoid institutionalization and provided that the state is eligible to receive Federal financial participation;
- Extraordinary circumstances include the inability of the parent/legal guardian to find and retain other qualified, suitable caregivers when the parent/guardian would otherwise be absent from the home and, thus, the parent/guardian must stay at home to ensure the member's health and safety. The member may request that the LRI (parent/guardian or spouse) be allowed to be employed by the member/EOR and provide services as approved in the member's current SDCB care plan. The request must include documentation showing all attempts to employ other available resources in the member's community, the challenges



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

the member and/or providers encountered, and why the member-chosen providers were unable to successfully provide the approved covered service as approved in the SDCB care plan;

- LRIs may not be paid for any services that they would ordinarily perform in the household for individuals of the same age who do not have a disability or chronic illness. This includes, but is not limited to, transportation of minors to and from school, activities and events; and
- Requests to employ a LRI must be submitted in writing to the MCO. The request must be approved or denied in writing by the appropriate MCO/UR staff member. The approval of a LRI must be renewed annually, at the same time as the NF LOC and SDCB care plan.
- Services provided by LRIs must:
 - Meet the definition of a SDCB covered service and be specified in the member's approved SDCB care plan;
 - Be provided by a SDCB member's parent/guardian or spouse who meets the provider qualifications and training standards specified in the SDCB rules and these service descriptions and qualifications for that covered service; and
 - Be paid at a rate that does not exceed the SDCB Range of Rates (9.A) for the specific service the LRI is approved to provide and be approved by the MCO/UR.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.10. SDCB Covered Services

All services are subject to the approval of the MCO/UR. Below is a list of SDCB covered services and related goods for members in SDCB, followed by a detailed service description:

- Behavior Support Consultation Services;
- Customized Community Support;
- Emergency Response;
- Employment Supports;
- Environmental Modifications;
- HH Aide;
- Nutritional Counseling;
- Private Duty Nursing;
- Related Goods;
- Respite;
- Self-Directed Personal Care Skilled Maintenance Therapy Services for Adults;
- Specialized Therapies; and
- Transportation (Non-Medical).

Descriptions for each of the above SDCB covered services are as follows.

Behavior support consultation services

- 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.

- Scope of Services:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Inform and guide the SDCB member, family, employees and/or vendors toward understanding the contributing factors to the SDCB member’s behavior;
 - 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;
 - Support effective implementation based on a functional assessment and subsequent SDCB care plans;
 - Collaborate with medical and ancillary therapies to promote coherent psychotherapeutic medications; and
 - Monitor and adapt support strategies based on the response of the SDCB member and his/her family, employees and/or vendors.
- Behavior Support Consultant Qualifications – Individual:
 - Provide a tax identification number;
 - Maintain a member file within HIPAA guidelines to include:
 - Member’s SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes; and
 - Training roster(s).
 - Have and maintain a current New Mexico license with the appropriate professional field licensing body; current licensure may be any of the following:
 - MD;
 - Licensed clinical psychologist;
 - Licensed psychologist associate (masters or PhD level);
 - LISW or LMSW;
 - LPCC;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Licensed professional counselor (LPC);
 - Licensed psychiatric nurse;
 - LMFT; or
 - Licensed practicing art therapist (LPAT).

- Behavior Support Consultant Qualifications - Provider Agency
 - Provide a tax identification number; and current business license issued by State, county or city government, if required;
 - Maintain a member file within HIPAA guidelines to include:
 - Member’s SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes; and
 - Training roster(s).
 - 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:
 - MD;
 - Licensed clinical psychologist;
 - Licensed psychologist associate (masters or PhD level);
 - LISW or LMSW;
 - LPCC;
 - LPC;
 - MSN/RNSC;
 - LMFT; or
 - LPAT.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Customized Community Supports

- Definition of Service
 - Customized community support services are designed to offer the SDCB member flexible supports that are related to the member’s qualifying condition or disability. Customized community supports may include participation in congregate community day programs and centers that offer functional meaningful activities that assist with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Customized community supports may include adult day habilitation, adult day health and other day support models. Customized community supports are provided in community day program facilities and centers and can take place in non-institutional and non-residential settings.
 - Customized community supports settings must be integrated and support full access of individuals receiving Centennial Care CBs to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, with the same degree of access as individuals not receiving Medicaid HCBS.
 - These services are provided at least four or more hours per day one or more days per week as specified in the member’s SDCB care plan. Customized community supports cannot duplicate any other SDCB service.
- Scope of Services
 - Customized Community Support services include, but are not limited to the following:
 - Provide supports in congregate and community day programs that assist with the acquisition, retention or improvement in self-help, socialization and adaptive skills;
 - Adult day health services;
 - Adult day habilitation services; and
 - Other day support model services.
 - Customized Community Supports Qualifications - Provider Agency:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Possess a current business license, if applicable;
- Meet financial solvency;
- Adhere to training requirements;
- Maintain member records for each member within HIPAA compliance;
- Develop and adhere to a records management policy;
- Develop and adhere to QA rules and requirements;
- Adult day health provider agencies must be licensed by New Mexico DOH as an adult day care facility pursuant to 7.13.2 NMAC; and
- Ensure all assigned staff meets the following qualifications:
 - Be at least 18 years of age;
 - Have at least one year of experience working with people with disabilities;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the member/member representative;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - 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
 - Meet any other service qualifications, as specified in the SDCB rules.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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Emergency Response

- 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.
- Scope of Services:
 - Testing and maintaining equipment;
 - Training SDCB members, caregivers and first responders on the use of the equipment;
 - 24-hour monitoring for alarms;
 - Checking systems monthly or more frequently if warranted (e.g., electrical outages, severe weather); and
 - Reporting member’s condition that may affect service delivery; and
 - Initial set-up and installation of Emergency Response Service devices is not a covered service; see the service description for environmental modification for allowance of the initial set-up and installation.
- Emergency Response Qualifications – Vendor/Agency
 - Comply with all laws, rules and regulations of the New Mexico State Corporation Commission for Telecommunications and Security Systems; and
 - Comply with all laws, rules and regulations from the Federal Communications Commission for telecommunications.

Employment Supports

- Definition of Service:
 - Employment support services provide support to the member in achieving and maintaining employment in jobs of his/her choice in his/her community. The member



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

must exhaust all available vocational rehabilitation supports prior to requesting Employment Supports on his/her SDCB care plan. Employment Supports cannot duplicate any other SDCB service. Employment Supports include two types of services: job coaching and job-development. The specific employment support service to be provided must be clearly described in the member's care plan and must address specific employment-related activities;

- Employment Supports will be provided by staff at current or potential work sites. If member is self-employed, Employment Supports may be provided in a setting other than a formal work site. When employment support services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by members receiving SDCB services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting. Employment Supports settings must be integrated in, and support full access for individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment, and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Centennial Care CBs; and
- 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 Individuals with Disabilities Education Act (IDEA).
- Employment Supports include the following services:
 - 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 (DVR) or through the New Mexico Department of Education. Job coaching services are available 365 days a year, 24 hours a day. Services are driven by the member's SDCB care plan, budget and job. Medicaid funds are not used to pay the member. Job coaches will adhere to the specific supports and expectations negotiated with the member and employer prior to service delivery; and



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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 DVR 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.
- Scope of job coach services:

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

- Provide support to members as contained in the SDCB care plan as to achieve his/her outcomes;
- Teach vocational skills in a workplace setting;
- Employ job-coaching techniques and help members learn to accomplish job tasks to the employer's specifications;
- Increase the member's capacity to engage in meaningful and productive interpersonal interactions with co-workers, supervisors and customers;
- 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;
- Identify specific information about the member's employment interests, preferences and abilities;
- 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;
- Monitor and evaluate the effectiveness of the service and provide reports or documentation to the member as requested in the SDCB care plan;
- Address behavioral, medical or other significant needs identified in the SDCB care plan;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Follow any individual specific therapeutic recommendations including speech, occupational and/or PT, behavioral support, special diets and other therapeutic routines that are noted in the SDCB care plan;
- 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;
- Monitor the health and safety of the member;
- Model behavior, instruct and monitor any work place requirements to the member;
- Adhere to professionally acceptable business attire and appearance, and communicate professionally and in a respectful manner; and
- Adherence to rules of the specific work place, including dress, confidentiality, safety rules and other areas required by the employer.
- Scope of job development services:
 - Identify potential employers and jobs in the area that provide work opportunities consistent with the member's preferences, interests and choice;
 - Negotiate job functions, hours and supervision in the member's best interest;
 - Conduct satisfaction surveys as requested by the member;
 - Broker relationships between the employer and the member in order to develop and maintain job success;
 - Identify potential employers and jobs in the area that provide work opportunities consistent with the member's preferences, interests and choices;
 - Conduct job task analysis to ensure appropriate job match(es);
 - Assess barriers to member skill development on the job and provide or obtain appropriate accommodations tailored to the SDCB member's ability to master task;
 - Interact professionally in individual and group contacts, on the phone, in writing with various levels of the company, including human resources and management;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Assist the employer with ADA issues, Work Opportunity Tax Credit eligibility, requests for reasonable accommodations, disability awareness training and workplace modification or make referrals to appropriate agencies;
 - Utilize, refer, and communicate with the DVR concerning job placement and referral activities consistent with industry and SDCB standards;
 - Utilize DWS Navigators and One-Stop Career Centers, Business Leadership Network (BLN), Chamber of Commerce, Job Accommodation Network (JAN), Small Business Development Centers, Retired Executive, Businesses, community agencies, and the New Mexico Employment Institute to achieve employment outcomes;
 - Maintain on-going communication with various levels of the employer company to assure satisfaction to both the member and the company;
 - During the time of service delivery, ensure the member's earnings and benefits are in accordance with Fair Labor Standards Act. Each member's earnings and benefits will be reviewed at least semi-annually during the SDCB care plan year to ensure the appropriateness of pay rates and benefits;
 - Conduct a vocational assessment or profile as deemed necessary upon request of the member;
 - Provide a career development plan as deemed necessary or upon the request of the member;
 - 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;
 - Verify and ensure that members receive job benefits and services such as paid time off, health insurance, retirement, awards, raises, performance reviews and training consistent with those in a similar job category; and
 - Provide career and skill development for advancement and integration in work-related activities or events.
- Job Coach Qualifications – Individual Provider:
 - Be at least 18 years of age;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Be qualified to perform the service and demonstrate capacity to perform required tasks;
- Be able to communicate successfully with the member;
- Experience as a job coach for at least one year;
- Experience for at least one year using job and task analyses;
- Trained on ADA;
- Trained on the purpose, function and general practices of the DVR;
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- 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 member's annual budget; and
- Meet any other service qualifications, as specified in the SDCB rules.
- Job Developer Qualifications – Individual Provider:
 - Be at least 18 years of age;
 - Pass CBC and abuse registry screen;
 - Experience as a job developer for at least one year;
 - Experience for at least one year developing and using job task and analyses;
 - Experience for at least one year working with the DVR, an independent living center or organization that provides Employment Supports or services for people with disabilities;
 - Trained on the purposes, functions and general practices entities such as:
 - DWS Navigators;
 - One-Stop Career Centers;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- BLN;
 - Chamber of Commerce;
 - JAN;
 - Small Business Development Centers;
 - Retired Executives; and
 - New Mexico Employment Institute.
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - 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
 - Meet any other service qualifications, as specified in the SDCB rules.
- Job Coach and/or Job Developer Qualifications – Provider Agency:
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - 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;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA rules and requirements;
 - Ensure job coaches have the following qualifications:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the member;
 - Experience as a job coach for at least one year;
 - Experience for at least one year using job and task analyses;
 - Trained on ADA;
 - Trained on the purpose, function and general practices of the DVR;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - 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 member's annual budget; and
 - Meet any other service qualifications, as specified in the SDCB rules.
- Ensure job developers have the following qualifications:
 - Be at least 18 years of age;
 - Experience as a job developer for at least one year;
 - Experience for at least one year developing and using job task and analyses;
 - Experience for at least one year working with the DVR, an independent living center or organization that provides Employment Supports or services for people with disabilities; and
 - Trained on the purposes, functions and general practices entities such as:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- DWS Navigators;
- One-Stop Career Centers;
- BLN;
- Chamber of Commerce;
- JAN;
- Small Business Development Centers;
- Retired Executives;
- New Mexico employment institute;
- 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;
- a-1 et seq. and 8.11.6 NMAC;
- Complete training on critical incident, abuse, neglect, and exploitation reporting;
- 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
- Meet any other service qualifications, as specified in the SDCB rules.

Environmental modification

- Definition of Service:

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



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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.

- Scope of Services:
 - Environmental adaptations include the following:
 - Installation of ramps and grab-bars;
 - Widening of doorways/hallways;
 - Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies;
 - Installation of lifts/elevators;
 - Modification of bathroom facilities (roll-in showers, sink, bathtub, and toilet modifications, water faucet controls, floor urinals, and bidet adaptations and plumbing);
 - Turnaround space adaptations;
 - Installation of specialized accessibility/safety adaptations/additions;
 - Installation of Trapeze and mobility tracks for home ceilings;
 - Installation of Automatic door openers/doorbells;
 - Installation of Voice-activated, light-activated, motion- activated and electronic devices;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Installation of Fire safety adaptations;
- Installation of Air filtering devices;
- Installation of heating/cooling adaptations;
- Installation of glass substitute for windows and doors;
- Installation of modified switches, outlets or environmental controls for home devices;
and
- Installation of alarm and alert systems, emergency response systems, and/or signaling devices.
- Environmental modification Qualifications – Individual Contractor and Agency Contractor:
 - Current business license;
 - Appropriate plumbing, electrician, contractor license; and/or
 - Appropriate technical certification or other license to perform the modification.
- The environmental modification provider must:
 - Provide a one-year warranty from the completion date on all parts and labor;
 - Have a working knowledge of environmental modifications and be familiar with the needs of persons with functional limitations in relation to environmental modifications;
 - Provide consultation to family members, providers and MCOs concerning environmental modification projects to the SDCB member's individual's residence, and inspect the final environmental modification project prior to the member/EOR requesting the final payment to ensure that the adaptations meet the approved plan as submitted and approved for environmental adaptation; and
 - Provider must establish and maintain financial reporting and accounting for each member.



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The environmental modification provider will submit the environmental modification Service Cost Quote Packet containing the following information and documentation to the MCO:
 - Environmental modification evaluation;
 - 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);
 - Letter of Acceptance of Service Cost Estimate signed by the SDCB member/EOR;
 - 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;
 - 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
 - Documentation demonstrating compliance with the ADA.
- The environmental modification provider must submit the following to the MCO, after the completion of work:
 - Letter of Approval of Work completed signed by the SDCB member/EOR; and
 - Photographs of the completed modifications.
- The MCO must submit a Care Coordinator Individual Assessment of Need to the provider.
- Reimbursement:

Environmental modification providers must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid PPA. Billing is on a project basis, one unit per environmental modification project. Reimbursement for

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

environmental modification services will be based on the negotiated rate with the SDCB member/EOR;

Environmental modification services are limited to \$5,000.00 every five 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-year time limit applies across all CB packages where environmental modifications are a covered service. Example: an ABCB member receives an environmental modification of \$2,300.00 leaving a \$2,700.00 available balance for future environmental modification. Six months later the ABCB member transitions to the SDCB, the member now has \$2,700.00 available for environmental modifications; and

Environmental modifications exclude those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the member, such as carpeting, fences, roof repair, storage sheds or other outbuildings, furnace replacement, insulation, and other general household repairs. Adaptations that add to the total square footage of the home are also excluded from this benefit except when necessary to complete an adaptation related to the member's medical condition.

Home Health Aide

- Definition of Service:

HH Aide services provide total care or assist a member in all activities of daily living. HH Aide services assist the member in a manner that will promote and improve the member's quality of life and provide a safe environment for the member. HH aide services can be provided outside the member's home;

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

HH Aides may provide basic non-invasive nursing assistant skills within the scope of their practice. HH Aides do not administer medication(s), adjust oxygen levels, perform any intravenous procedures or perform sterile procedures. HH Aide services are not duplicative of self-directed PCS.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---	--

- Scope of Services:
 - Provide personal hygiene (e.g. sponge bathing, showering, bed shampooing, shaving, oral hygiene dressing);
 - While under the supervision of a licensed physical therapist or licensed nurse (RN or LPN), assist with ambulation, transfer and range of motion exercises;
 - Assist with menu planning, meal/snack preparation and assist member with eating as necessary;
 - 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;
 - Provide homemaking services (e.g. laundry, linen change, cleaning);
 - Pick up medication(s);
 - Assist or prompt member in self-administration of medication(s);
 - Observe general condition of member and report changes to supervisor;
 - Document SDCB member's status and services furnished, infection control procedures; and
 - Recognize emergencies and adhere to emergency procedures.
- HH Aide Qualifications – Agency Provider:
 - Licensed in New Mexico as an HH agency, RHC or FQHC;
 - Possess current business license;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each SDCB member within HIPAA compliance;
 - Develop and adhere to records management policy;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- Develop and adhere to QA policies and processes;
- Supervision must be performed by an RN. 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; and
- Ensure all assigned staff meets the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Have successfully completed a HH aide training program, as described in 42 CFR 484.36(a)(1) and (2); or have successfully completed a HH aide training program pursuant to 7.28.2.30 NMAC. Copies of CNA certificates must be maintained in the personnel file of the HH aide;
 - Be able to communicate successfully with the member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting; and
 - Meet any other service qualifications, as specified in the SDCB rules.

Nutritional Counseling

- 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.
- Scope of Services:
 - Assessment of nutritional needs;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- Development and/or revision of the SDCB member’s nutritional plan; and
- Counseling and nutritional intervention and observation and technical assistance related to implementation of the nutritional plan.
- Nutritional Counseling Qualifications - Individual Provider:
 - Be licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.
- Nutritional Counseling Qualifications - Agency Provider:
 - Current business license; and provide a tax identification number;
 - Ensure staff meet the following qualifications; and
 - Licensed per the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq.

Private Duty Nursing for Adults

- Definition of Service:
 - Private duty nursing for adult services includes activities, procedures, and treatment for a member’s physical condition, physical illness or chronic disability. Children (individuals under the age of 21) receive this service through the State plan EPSDT.
- Scope of Services:
 - Private duty nursing services for adults may include performance, assistance and education with the following tasks:
 - Medication management, administration and teaching;
 - Aspiration precautions;
 - Feeding tube management, gastrostomy and jejunostomy;
 - Skin care;
 - Weight management;
 - Urinary catheter management;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Bowel and bladder care; wound care; health education and screening;
- Infection control;
- Environmental management for safety;
- Nutrition management;
- Oxygen management;
- Seizure management and precautions;
- Anxiety reduction;
- Staff supervision; and
- Behavior and self-care assistance.
- Private Duty Nursing Qualifications – Agency:
 - Licensed in New Mexico as a HH Agency, RHC or FQHC agency;
 - Possess current business license;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each member within HIPAA compliance;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA policies and processes;
 - Ensure all assigned staff meet the following qualifications;
 - Licensed by the New Mexico State Board of Nursing as a RN or LPN;
 - Demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the member;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

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

Related Goods

- Definition of Service:

Related Goods are services, goods, and equipment, including supplies, fees or memberships (such as for conferences or classes), which support the SDCB member to remain in the community, decrease the need for other Medicaid services and reduce the risk for institutionalization. Related goods must promote personal safety and health, accommodate the SDCB member in managing his/her household and/or facilitate ADLs. The related goods must not be available through another source including the Medicaid State Plan and/or Medicare, and the SDCB member must not have the personal funds needed to purchase the goods; and

Related goods must be documented in the SDCB care plan in a manner that clearly describes how the related good will advance the desired outcomes in the SDCB member's care plan. Related goods must be linked to the SDCB member's identified needs and are intended for the sole use of the SDCB member, and one caregiver, if appropriate. All related goods, must be approved by the MCO/UR. The cost and type of related good is subject to approval by the MCO/UR. SDCB members are not guaranteed the exact type and model of



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

related good that is requested. The Support Broker and/or the Care Coordinator can work with the SDCB member to find other (including less costly) alternatives. Items that are purchased with SDCB funds cannot be returned for store credit, cash or gift cards. Experimental or prohibited treatments and related goods are excluded. For members who enter the SDCB program after January 1, 2019, related goods are limited to a total maximum of \$2,000.00 annually.

- **Scope of Services:**

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

Related goods must meet all of the following requirements:

- Are related to a need or goal identified in the approved care plan;
- Are for the purpose of increasing independence or substituting for human assistance, to the extent the expenditures would otherwise be made for that human assistance;
- Promote opportunities for community living and inclusion;
- Are able to be accommodated within the member’s budget without compromising the member’s health or safety; and
- Are provided to, or directed exclusively toward, the benefit of the member.

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

- Goods or services that are considered primarily recreational or diversional;
- Cell phones and cell phone service for members who are minors (these are items that LRI such as a parent/guardian, or spouse would ordinarily purchase for household members of the same age who do not have a disability or chronic illness);



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Cell phone services including fees for data and GPS in excess of \$100.00 per month or more than one cell phone per SDCB member;
- Cell phone services that include more than one cell phone or cell phone line per member; cell phone service, including data, is limited to the cost of \$100.00 per month;
- Room and board, meaning shelter expenses (including property-related costs such as home and property maintenance, insurance policies, utilities and all deposits; and all food items other than nutritional supplements as approved in the SDCB care plan);
- Purchase of usual and customary furniture/home furnishings,
- Regularly scheduled upkeep, maintenance and repairs of a home, addition of fences, insulation, construction of storage sheds or other outbuildings, except upkeep and maintenance of modifications or alterations to a home which are an accommodation directly related to the member's qualifying condition or disability;
- Regularly scheduled upkeep, maintenance and repairs of a vehicle or van, or tire purchase or replacement, except upkeep and maintenance of modifications or alterations to a vehicle or van, which is an accommodation directly related to the member's qualifying condition or disability.
- Purchase, lease, or rental of a vehicle, including recreational vehicles;
- Memberships/fees related to religious activities/events;
- 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;
- Purchase of insurance policies, such as automobile, health, life, burial, renter's, home-owner, service warrantees or other such policies, including the purchase of cell phone insurance;
- Personal goods or items not related to the member's qualifying condition or disability, including clothing and personal hygiene products and accessories;
- Moving expenses including but not limited to the cost of moving truck rental, gas/mileage, labor, storage, moving equipment and supplies;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Vacation expenses, including means of transport, guided tours, meals, tips, lodging or similar recreational expenses including fuel, mileage or driver time reimbursement for vacation travel by an automobile;
 - Costs associated with conferences or classes, including airfare, lodging, mileage/gas, or meals;
 - Training expenses for employees;
 - Professional housecleaning or yard maintenance;
 - Formal academic degrees or certification-seeking education, educational services covered by IDEA, or vocational training provided by the public education department, DVR; and
 - For electronics such as cell phones, computers (including desktop, laptop, and tablets), monitors, printers and fax machines, copiers, and other electronic equipment, no more than one of each type of item may be purchased at one time, and member electronics may not be replaced more frequently than once every three years.
- Related Goods Qualifications - Vendor Agency Provider:
 - Valid tax identification for the state and Federal governments.

Respite

- Definition of Service:
 - Respite is to be used to give the primary caregiver a break on an episodic basis in the event of an emergency or to prevent burnout. Respite provides a temporary relief to the primary caregiver of a SDCB member during times when the caregiver would normally provide unpaid care. Respite services can be provided in the SDCB member's home, the provider's home, in community setting of the family's choice (e.g., community center, swimming pool and park, or at a center in which other individuals are provided care); and
 - Respite services may be provided by eligible individual respite providers; RN or LPN; or respite provider agencies.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- **Scope of Services:**

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

- For members meeting NF LOC, respite services are limited to a maximum of 300 hours annually per care plan year provided there is a primary caregiver. The 300-hour respite service applies across all CB 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;
 - Assist with routine ADLs;
 - Enhance self-help skills, leisure time skills and community and social awareness;
 - Provide opportunities for leisure, play and other recreational activities;
 - Provide opportunities for community and neighborhood integration and involvement;
 - Provide opportunities for the SDCB member to make his/her own choices with regards to daily activities;
 - Respite services do not include the cost of room and board;
 - Cannot be used for purposes of day-care; and
 - Cannot be provided to school age children during school hours.
- **Respite Qualifications – Individual Provider:**
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the SDCB member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- 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;
 - Meet any other service qualifications, as specified in the SDCB rules and the Manual; and
 - Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN.
- Respite Qualifications - Provider Agency:
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each SDCB member within HIPAA compliance;
 - Develop and adhere to a records management policy;
 - Develop and adhere to QA rules and requirements; and
 - Ensure all assigned staff meet the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the SDCB member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Complete SDCB member specific training; the evaluation of training needs is determined by the SDCB member or his/her legal representative; member is also

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

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 SDCB annual budget;

- Individual RN/LPN providers must be licensed by the New Mexico State Board of Nursing as an RN or LPN; and
- Meet any other service qualifications, as specified in the SDCB rules and the Manual.

Self-Directed Personal Care

- Definition of Service:

Self-directed PCS are provided on a continuing basis to assist the member with accomplishing tasks he/she would normally do for him/herself if he/she did not have a disability. Self-directed PCS are provided in the member's home and in the community, depending on the member's needs. The member/EOR identifies the self-directed personal care worker's training needs. If the SDCB member/EOR is unable to do the training him/herself, the SDCB member/EOR arranges for the needed training;

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, Self-directed PCS 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; and this service is not available for members under age 21 because PCS are covered under the Medicaid State Plan as expanded EPSDT benefits for members under age 21.

- Scope of Services:
 - Self-directed PCS include but are not limited to the following:
 - Assist the member with ADLs;
 - Perform general household tasks, not including services such as yard maintenance;
 - Provide companionship to acquire, maintain or improve social interaction skills in the community; and

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---	---

- Attend trainings as designated by the member in the care plan.
- Self-Directed Personal Care Qualifications – Individual Provider:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the member;
 - 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 and the National Sex Offender Registry;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - 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 member’s annual budget;
 - Use the State-approved EVV system to record location of services and time worked; and
 - Meet any other service qualifications, as specified in the SDCB rules.
- Self-Directed Personal Care Qualifications – Agency Provider:
 - HHAs must hold an HHA license;
 - Possess a current business license, if applicable;
 - Meet financial solvency;
 - Adhere to training requirements;
 - Maintain individual records for each SDCB member within HIPAA compliance;
 - Develop and adhere to a records management policy;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- Develop and adhere to QA rules and requirements; and
- Ensure all assigned staff meet the following qualifications:
 - Be at least 18 years of age;
 - Be qualified to perform the service and demonstrate capacity to perform required tasks;
 - Be able to communicate successfully with the member;
 - Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29-17-2 et seq. and 7.1.9 NMAC and an abuse registry screening pursuant to NMSA 1978, Section 27-7a-1 et seq. and 8.11.6 NMAC and the National Sex Offender Registry;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - 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 member's annual budget;
- Ensure employees use the State-approved EVV system to record location of services and time worked; and
 - Meet any other service qualifications, as specified in the SDCB rules and the Manual.

Skilled Maintenance Therapies Services

- Definition of Service:

Skilled maintenance therapies are provided when Medicaid State Plan skilled therapy services are exhausted. Adult members in SDCB access therapy services under the Medicaid State Plan for acute and temporary conditions that are expected to improve significantly in a reasonable and generally predictable period of time. A signed therapy referral for treatment must be obtained from the member's PCP. The referral will include

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

frequency, estimated duration of therapy, and treatment/procedures to be rendered.

Therapy services provided to adults in SDCB are to focus on health maintenance, improving functional independence, community integration, socialization, exercise or to enhance supports and normalization of family relationships.

- PT is the diagnosis and management of movement dysfunction and the enhancement of physical and functional abilities;
 - OT 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; and
 - SLT 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.
- Scope of Services
 - PT:
 - Diagnostic activities to determine the dysfunction of physical and functional activities;
 - Activities to increase, maintain or reduce the loss of functional skills;
 - Treat specific condition(s) clinically related to a member’s qualifying condition or disability;
 - Activities to support the member’s health and safety needs; and
 - Identify, implement and train on therapeutic strategies to support the member, family and/or staff in the home setting or other environments as addressed in the SDCB care plan.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---	---

- OT:
 - Diagnostic activities to determine skills assessment and treatment;
 - Write treatment program to improve one’s ability to perform daily tasks;
 - Comprehensive home, employment and/or volunteer sites evaluations with adaptation recommendations;
 - Provide guidance to family members and caregivers;
 - Make assistive technology recommendations and provide usage training for members, family and staff; and
 - 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.

- Speech and Language Pathology:
 - Improve or maintain the member’s capacity for successful communication or to lessen the effects of the member’s loss of communication skills;
 - Consultation on usage and training on augmentative communication devices;
 - Activities to improve or maintain the member’s ability to eat food, drink liquid and manage oral secretions with minimal risk of aspiration or other injuries or illness related to swallowing disorders; and
 - Activities to identify, implement, and train on therapeutic strategies to support the member, his/her family and/or staff consistent with the member’s Care Plan.

- Therapy Qualifications – Individual Therapist Provider:
 - Provide a tax identification number; and
 - Maintain a case file within HIPAA guidelines for the member to include:
 - Member’s SDCB care plan;
 - Reports as requested in the care plan;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Contact notes;
- Training roster(s); and
- Assessments for environmental modification requests.
- Licensures:
 - 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;
 - 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
 - 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.
- Therapy Qualifications – Provider Agency:
 - Current business license;
 - Provide tax identification number;
 - Ensure physical therapists maintain a case file within HIPAA guidelines for the member to include:
 - Member’s SDCB care plan;
 - Reports as requested in the SDCB care plan;
 - Contact notes;
 - Training roster(s); and
 - Environmental modification requests.
 - Ensure therapists has appropriate license for service:

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- 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.;
- Occupational therapists will be licensed as per the New Mexico Regulation; Licensing Department; Occupational Therapy Act NMSA 1978, Section 61-12A- 1et.seq.; and
- 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.

Specialized Therapies Services

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

Experimental or investigational procedures, technologies or therapies and those services covered in Medicaid State Plans are excluded. For members who enter the SDCB program on or after January 1, 2019, specialized therapies are limited to a total maximum of \$2,000.00 annually.

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

- **Scope of Services:**

- 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 PH and increased mental clarity.

Acupuncture may provide effective pain control, decreased symptoms of stress,



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

improved circulation and a stronger immune system, as well as other benefits. See Acupuncture and Oriental Medicine Practitioners 16.2.1 NMAC.

- Biofeedback uses visual, auditory or other monitors to provide SDCB members physiological information of which they are normally unaware. This technique enables a member to learn how to change physiological, psychological and behavioral responses for the purposes of improving emotional, behavioral and cognitive health performance. Biofeedback may assist in strengthening or gaining conscious control over the above processes in order to self-regulate. Biofeedback is also useful for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm or weakness;
- 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 Chiropractic Practitioners 16.4.1 NMAC;
- 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;
- Hippotherapy is a physical, occupational and SLT 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



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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. Hippotherapy must be performed by a physical therapist, occupational therapist, or speech therapist licensed by the New Mexico Regulation and Licensing Department;

- 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;
- 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; and
- 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.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

- Specialized Therapy Qualifications – Individual Provider:
 - Current New Mexico state license as applicable:
 - Acupuncture and Oriental medicine license;
 - Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;
 - Chiropractic Physician license;
 - 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;
 - Hippotherapy – licensed occupational therapist, physical therapist, or speech therapist;
 - Massage therapy license; and
 - Naprapathic physician license.
 - 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.
- Specialized Therapy Qualifications - Provider Agency:
 - Current business license;
 - Tax identification number; and
 - Group practice/vendor staff must hold current New Mexico licensure and training in their respective discipline as follows:
 - Acupuncture and Oriental Medicine license;
 - Biofeedback – license in a healthcare profession whose scope of practice includes biofeedback, and appropriate specialized training and clinical experience and supervision;

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

- Chiropractic Physician license;
- 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;
- Hippotherapy – license in a health care profession whose scope of practice includes Hippotherapy and appropriate specialized training and experience;
- Massage therapy license; and
- Naprapathic physician license.

Start-Up Goods

- Definition of Service:

Start-up goods are available to a member who is transitioning from the ABCB to the SDCB for the first time. Start-up goods are limited to one time. Start-up goods help the member in self-directing his or her services. Examples of start-up goods include, but are not limited to a computer, fax machine, and printer. All start-up goods must be approved by the MCO. The cost and type of related good is subject to approval by the MCO. Start-up goods must be purchased during the member’s first budget period. Start-up goods are limited to \$2,000.00.

Transportation (Non-Medical)

- Definition of Service:

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



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Non-medical transportation may be reimbursed:

- To the driver by the mile; and/or
- Through the purchase of a bus pass or local taxi.

Payments are made to the member's individual transportation employee or vendor or to a public or private transportation service vendor. Payments cannot be made to the SDCB member. Whenever possible, natural supports should provide this service without charge. For members who enter the SDCB program on or after January 1, 2019, SDCB non-medical transportation is limited to a total maximum of \$1,000.00 annually.

- **Scope of Services:**

The service will be provided as specified in the member's SDCB care plan. SDCB non-medical transportation services cannot be used instead of, or to replace, medical transportation services available under the Medicaid State Plan; and

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

- **Transportation Qualifications - Individual Provider:**

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

- **Transportation Qualifications – Provider Agency:**



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Current business license;
- Valid tax identification number;
- Have a current basic First Aid kit in the vehicle;
- Each vehicle will contain a current insurance policy and registration; and
- Ensure drivers meet individual qualifications:
 - Be at least 18 years of age;
 - Possess a valid New Mexico driver's license;
 - Be free of physical or mental impairment that would adversely affect driving performance
 - No driving while intoxicated convictions within the previous two years;
 - No chargeable (at fault) accidents within the previous two years;
 - Have current CPR/First Aid certification;
 - Complete training on critical incident, abuse, neglect, and exploitation reporting;
 - Trained on New Mexico Department of Health Improvement (DHI) Critical Incident Reporting and Procedures; and
 - Possess current insurance policy and registration.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.11. Self-Directed Non-Covered Services

When a member requests a non-covered service or good, the Support Broker and/or Care Coordinator shall work with the member to find other (including less costly) alternatives.

Services and goods that are not covered by the SDCB program include, but are not limited to:

- The SDCB Program is the payer of last resort; and
- Any service or good, the provision of which would violate Federal or State statutes, rules or guidance. This includes services that are recreational or diversional, which are not deemed eligible SDCB services by CMS. Recreational and diversional in nature is defined as inherently and characteristically related to activities done for enjoyment. This includes, but is not limited to tickets for movies, theatrical and musical performances, sporting events, zoos or museums.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

9.12. SDCB Budget and Care Plan Approval Process

The Care Coordinator adds the member to FOCo*Online* 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 FOCo*Online*.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.13. Initial SDCB Budget Determination Process

The SDCB budget is determined by the Care Coordinator and is based on two factors: the needs identified in the CNA, and the amount and type of services the member has been receiving in the ABCB. Both of these evaluations are used to assign the SDCB budget amount for development of the SDCB care plan. The Care Coordinator shall provide the Support Broker with the SDCB budget amount.

The member must receive his/her HCBS in the ABCB for a minimum of 120 calendar days before transferring to the SDCB. The initial 12-month SDCB budget shall be pro-rated based on the number of months already completed in the ABCB. The SDCB member may request a new CNA if the SDCB member thinks his/her needs were not adequately addressed in the initial CNA.

	<p align="center">Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.14. Initial SDCB Care Plan Approval Process

Once the Care Plan is developed, the Support Broker, in cooperation with the member, shall inform the Care Coordinator that the Care Plan is ready for review. Once the Care Coordinator reviews the Care Plan, the Care Coordinator shall formally submit the care plan in *FOCoSonline* to the MCO for review and approval/denial decisions. The member’s Care Plan must be reviewed and each individual requested goal approved or denied by the MCO and written notification must be sent to the member before any services may be utilized and related goods may be purchased. If, during the process of reviewing the Care Plan and all subsequent Care Plan revisions, the MCO is unable to make a decision on a goal, due to insufficient information, the MCO shall initiate an RFI via *FOCoSonline*. The MCO shall provide written notification to the member and the Support Broker, specifying what is needed by the MCO to satisfy the RFI. It is the member’s responsibility to provide a timely and complete response to the RFI. The Support Broker/Care Coordinator may assist the member in obtaining the requested documents to fulfill the RFI. The 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 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.

If the Care Coordinator or MCO identify 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 calendar days from the date of the RFA notification. If the RFA is not addressed by the Support Broker or Care Coordinator within five calendar days from the date of the RFA letter, the service or good shall be denied by the MCO/UR

The MCO will notify the member, Care Coordinator, and Support Broker in writing when a determination has been made on the Care Plan. The determination may be a full approval, a partial approval, or a full denial. The MCO shall indicate which goal(s) of the 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 care plan/budget to process payment for the approved amount of SDCB services and related goods.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

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

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

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

9.15. 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 budget based on the assessed needs identified in the CNA. The budget is determined annually and the budget amount may differ from year to year. The budget shall not be higher than the cost of care for persons served in a private NF, 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 care plan/budget, the Support Broker shall open the new Working Plan shell in *FOCoSonline*, with the begin and end dates for the upcoming SDCB Care Plan. Upon the annual SDCB budget determination, the Care Coordinator shall enter the SDCB budget amount in *FOCoSonline*, allowing the member and Support Broker to begin developing the upcoming year’s Care Plan.

	<p align="center">Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.16. Annual SDCB Care Plan Development and Approval Process

At a minimum, the Care Plan must be developed and submitted to the MCO for review annually, and no less than 30 calendar days prior to the expiration of the existing care plan/budget. This 30 calendar day timeframe allows enough time for the Care Coordinator and MCO to make an informed and accurate determination of all requested services before the existing care plan/budget expires. The MCO will notify the member, Care Coordinator, and Support Broker in writing when a determination has been made on the Care Plan request. The determination may be a full approval, a partial approval, or a full denial. The MCO shall indicate which goal(s) of the Care Plan have been approved or denied in FOCo*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).

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.17. SDCB Budget and Care Plan Approval Process for Individuals Who Transitioned from the MI VIA Waiver Program

Prior to 1/1/2014, the Mi Via TPA approved many Mi Via employees/vendors at a reimbursement rate which was above the maximum Mi Via rate for a particular Mi Via service. The higher reimbursement rates are 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 provider shall not exceed the current approved SDCB range of rates (9.A) for any SDCB covered service. When the aforementioned situation occurs, the budget may be reduced by the corresponding amount, if the SDCB member has no other legitimate SDCB need(s).

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

At each annual assessment and budget determination, the Care Coordinator shall determine if the member has underutilized his/her current SDCB care plan/budget. Underutilization is defined as using less than 75% of the total budget by the end of quarter three of the 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 service for the upcoming 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 budget for the upcoming care plan year/budget.

If overutilization of the Care Plan/budget is identified at any time during the care plan/budget year, the MCO shall not increase the current budget and level of services without identifying the need for a new CNA, and determining whether all other available resources have been exhausted. Overutilization is defined as using more than: 1) 50% of the budget by the end of quarter two of the member’s current care plan year; 2) 75% of the budget by the end of quarter three of the member’s current care plan year; or 3) 100% of the budget by the end of quarter four of the member’s current Care Plan year.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	---	--

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

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.18. Denials, Revisions and Reconsiderations of the SDCB Care Plan

- Denials:

The MCO shall send final decisions to the 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.

- Revisions:

The 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 Care Plan, these services must not be able to be acquired through other programs or sources. The 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 member with exploring other available resources.

The member must provide written documentation of the change in needs or circumstances as specified in the Manual. The member submits the documentation to the Care Coordinator/Support Broker. In *FOCoSonline*, the member or the member's legal representative and the Support Broker initiate the process to modify the Care Plan by developing a revision in *FOCoSonline* and forwarding the completed request for a 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 budget.

The Care Plan may be revised once the original care plan has been submitted and approved. Only one Care Plan revision may be submitted at a time, for example, a Care

	<p align="center">Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
---	---	--

Plan revision may not be submitted if an initial Care Plan or prior Care Plan revision request is under initial review by the MCO/UR.

Other than for critical health and safety reasons, Care Plan revision requests may not be submitted to the MCO within the last 60 calendar days prior to the expiration date of the current Care Plan /budget. This constraint does not apply to environmental modifications requests, as environmental modification work is not tied to a specific care plan year and the funding is not part of the overall SDCB budget amount.

Anytime a member exits SDCB and transfers to ABCB, another Medicaid waiver such as the DD Waiver, 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.

- Reconsiderations:

If the Care Plan, or a part of the Care Plan, is not approved, the Care Coordinator and/or Support Broker assists the 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 within 30 calendar days of the date on the denial notice. Reconsideration requests must be made by the Support Broker through *FOCoSonline* and additional documentation or additional clarifying information must be submitted in writing regarding the member’s request for reconsideration of the denied services or related goods.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

9.19. SDCB Care Plan Review Criteria

Services and related goods identified in the member’s requested Care Plan may be considered for approval if all the following requirements are met:

- The services or related goods must be responsive and directly related to the member’s qualifying condition or disability;
- The services or related goods must address the member’s clinical, functional, medical or habilitative needs;
- The services or related goods must accommodate the member in managing his/her household;
- The services or related goods must facilitate ADLs;
- The services or related goods must promote the member’s personal health and safety;
- The services or related goods must afford the member an accommodation for greater independence;
- The services or related goods must support the member to remain in the community and reduce his/her risk for institutionalization;
- The services or related goods must be documented in the member’s Care Plan and facilitate the desired outcomes stated in the member’s Care Plan;
- The service or related good is not prohibited by Federal and State statutes, rules and guidance;
- Each service or good must be listed as an individual line item; when services or related goods must be “bundled” the Care Plan must document why bundling is necessary and appropriate;
- The proposed Care Plan is within the member’s approved budget;
- The proposed rate for each service is within the SDCB range of rates (9.A) for that chosen service;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The proposed cost for each good is reasonable, appropriate and reflects the lowest available cost for that chosen good; and
- The estimated cost of the service or good is specifically documented in the member's Care Plan.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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9.20. Implementation of the SDCB Care Plan

- Enrolling SDCB Employees and Vendors:
 - Pre-Hire Packet:
 - Before providing services to a member, most employees and vendors are required to submit the appropriate State-approved pre-hire packet to the FMA and pass the COR screening. The exception to this requirement is when the vendor has a professional license, such as an RN or Speech Language Pathologist (SLP) that qualifies them to provide the approved service. The FMA is responsible for maintaining, distributing and processing the pre-hire packets. For answers to questions about hiring employees or vendors and to obtain the pre-hire packet, an EOR shall contact the FMA Help Desk at 1-866-916-0310;
 - Potential SDCB employees are required by New Mexico law through the caregivers' criminal history screening act (7.1.9 NMAC) to pass a 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 email 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 email address listed in FOC*o*Online, 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 New Mexico 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; and

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	--

- No SDCB provider shall exceed 40 hours paid work in one work week per EOR. If an employee works for more than one EOR, the employee shall not exceed 40 hours paid work in one work week, per EOR.
- Credentialing Requirements:
 - The State has set credentialing requirements for credentialing providers of SDCB services, and these requirements have been approved by CMS. The FMA shall ensure these requirements are met. These requirements include certain licenses which must be submitted by the potential SDCB provider to the FMA, and are described in 9.B & 9.C (Vendor and Employee Credentialing Requirements). Services cannot be provided to a member until the SDCB care plan is approved, and there is a credentialed and approved provider linked to the approved SDCB goal.
- Other Required 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 by contacting the FMA. It is the member/EOR's responsibility to ensure all employment documents are submitted to the FMA.

For potential SDCB employees, the required documents are included in the Employee Packet:

- Employment Agreement;
- Employee Information Form;
- Declaration of Relationship Form;
- Federal W-4; and
- State W-4.

For potential SDCB vendors who are providing services the required documents are included as part of the Vendor Packet:

- Vendor Agreement;
- Vendor Information Form; and

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

- Federal W-9.

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

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.

- Purchasing Services and Related Goods:
 - Timesheets:
 - ASDCB employee (or EOR) must enter and approve the employee(s)'s timesheet(s) in *FOCoSonline* unless he/she is approved for an exception to fax timesheets to the FMA. Upon completing the *FOCoSonline* training, a new user will receive a *FOCoSonline* Account Authorization form (via email). Once the new user completes the *FOCoSonline* Account Authorization form and faxes it to the FMA Technical Department, the user will receive an email with his/her password and login instructions;
 - 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; and
 - An 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.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 9: Self-Directed Community Benefit</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	--	--

- Invoices:
 - Vendor PRF 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 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/deliver 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. Uncashed checks may be voided by the FMA after six months; and
 - Although an EOR must submit timesheets online (after completing necessary FOCo*Online* training and paperwork), it is not possible to submit invoices online. PRFs and invoices must be faxed or sent electronically to the FMA for processing. If a SDCB member/EOR has access to FOCo*Online*, he/she should review his/her payments and monitor them as they are being processed. In addition, the SDCB member, EOR, or AR may run reports through FOCo*Online* to monitor spending activity.

- Return to Member (RTM) Process:
 - 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 unsuccessful phone call attempts to the EOR have been made and the corrected document still has not been received, the FMA will send an email to the EOR (provided the EOR has an email address in FOCo*Online*) with a copy to the Care Coordinator and Support Broker. If the EOR does not have an email address in FOCo*Online*, the FMA will send an email to the Care

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

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 FOCo*Online* contain the EOR's correct contact information. If the EOR contact information needs to be updated, please contact the FMA Help Desk for assistance.

- Employee and Vendor Pay Rates:
 - Employee and vendor pay rates must be approved in the member's 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 completed 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 FOCo*Online*. 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 FOCo*Online* and in the 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.

- 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.

- SDCB Care Plan Expenditure Safeguards:
 - The SDCB member holds the primary responsibility for monitoring and ensuring his/her approved SDCB care plan is spent appropriately; however, the Care



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Coordinator and Support Broker must support the SDCB member in this activity. The FMA also assists in ensuring that funds are spent appropriately through payment of approved services and related goods according to the approved SDCB care plan and Employee/Vendor Agreements;

- The member/EOR is responsible for reviewing his/her monthly spending report which is available to each member/EOR by the FMA on a monthly basis. The SDCB member/EOR may also obtain “real-time” information on service usage and spending by directly accessing *FOCoSonline*. It is highly recommended that members/EORs obtain access to *FOCoSonline* so that they can effectively monitor their care plan/budget and track spending. Monthly training for *FOCoSonline* is offered for SDCB members, employees, and EORs. If interested in training, the SDCB member, employee, or EOR should contact the FMA Help Desk for assistance;
- The Support Broker is required to review the member’s SDCB care plan expenditures during each quarterly face-to-face contact with the member. The Care Coordinator and/or Support Broker will provide the member with expenditure information and discuss any concerns. If the 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; and
- The FMA is responsible for processing payments for approved SDCB services and related goods. When an invoice or timesheet is received by the FMA, they verify that the particular service or good is approved in the 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 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 Care Plan, the FMA will send an RTM letter to the member and make three attempts to contact the member by telephone to inform the EOR/member of the insufficient funds issue.

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

9.21. Transitions, Terminations, and Reinstatement Processes

Upon initial eligibility for the CB, the member will be eligible for the 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 utilize CB services in the ABCB prior to transitioning to SDCB. If the member has a short-term admission to an NF, the 120 calendar days does not start over. The member must always end the current CB model on the last day of the month and start the new CB model on the first day of the following month. The Care Coordinator must ensure there is no break in CB services during model switches. Examples of transition for members who enter an NF include, but are not limited to, the following:

- The member only has a waiver COE (090, 091, 092, 093 or 094) and is institutionalized more than 60 days, the member must apply for IC and submit their name back on the Central Registry. They then must receive a Community Reintegration allocation. If, when they are discharged, they still have living arrangements in place, they are not required to complete the 120 days in ABCB again;
- 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 days 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; and
- 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 days. 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.

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 day's

	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	---	---

advance notice regarding his/her intent to withdraw from the SDCB. All transfers will become effective on the 1st day of the following month.

Involuntary Termination

- Reasons SDCB members may be involuntarily terminated from the SDCB and offered services through the ABCB include, but are not limited to, the following circumstances:
 - 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 separate occasions where the member /EOR have received training, education or technical assistance, or a combination of both;
 - 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:
 - The SDCB member refuses to include and maintain services in his/her SDCB Care Plan that would address health and safety issues identified in the member’s CNA or challenges the assessment after repeated and focused technical assistance and support from program staff, Care Coordinator/Support Broker, or FMA;
 - 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;
 - 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;



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The SDCB member expends his/her entire SDCB budget prior to the end of the SDCB Care Plan year;
- The SDCB member commits Medicaid fraud such as, for example, altering SDCB employee/vendor payment checks;
- The final decision to terminate a SDCB member and move him/her to ABCB is made by the State. The MCO shall submit sufficient documentation to the State for approval of the involuntary termination request. Upon State approval, the MCO shall notify the member of the involuntary termination, in writing, and shall include appeal rights per HSD rules. The MCO must transition the member to the ABCB with no break in services. The transition must be completed within 90 calendar days of the date of HSD approval. SDCB involuntary terminations may become effective any time during the month;
- Requests to be reinstated back to SDCB may be made one time during a 12-month period. The member must make the request to his/her MCO in writing. All members shall be required to participate in SDCB training prior to their reinstatement;
- A 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; and/or
- 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 the issues previously identified as reasons for termination have been adequately addressed prior to the reinstatement.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.22. Appendices

9.22.1 SDCB Range of Rates Chart

9.22.2 SDCB Vendor Credentialing Requirements

9.22.3 Employee Credentialing Requirements Grid

9.22.4 Vendor Toolkit

9.22.5 Employee Toolkit



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

9.22.1. SDCB Range of Rates Chart

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Self-Directed Personal Care	99509	99509	Hour	minimum wage - \$14.60
HH Aide	S9122	S9122	Hour	\$16.32
Employment Supports (includes Job Coach)	T2019	T2019	15 min.	\$2.15 - \$6.93
Job Developer (Per job that is developed for member)	T2019	T2019JD	Each	\$100-\$700
Customized Community Supports (adult day hab.)	S5100	S5100	15 min.	\$1.36-\$8.82
PT	G0151	G0151	15 min.	\$13.51 - \$24.22
OT	G0152	G0152	15 min.	\$12.74 - \$23.71
Speech/Language Pathology	G0153	G0153	15 min.	\$16.06 - \$24.22
Behavior Support Consultation	H2019	H2019	15 min.	\$12.24 - \$20.65
Private Duty Nursing – Adults- RN	T1002	T1002	15 min.	\$10.90
Private Duty Nursing – Adults- LPN	T1003	T1003	15 min	\$6.79
Nutritional Counseling	S9470	S9470	Hour	\$42.83
Acupuncture	97810	97810	15 min.	\$12.50-\$25.00
Biofeedback	90901	90901	Visit	\$50.00-\$100.00
Chiropractic	98940	98940	Visit	\$50.00-\$100.00
Cognitive Rehabilitation Therapy	97532	97532	15 min.	\$12.50-\$25.00
Hippotherapy	S8940	S8940	Visit	\$50.00-\$100.00
Massage Therapy	97124	97124	15 min.	\$12.50-\$25.00
Naprapathy	S8990	S8990	Visit	\$50.00-\$100.00
Native American Healers	S9445	S9445	Session	As approved by MCO
Respite Standard (not provided by RN, LPN or HHA)	T1005	T1005SD	15 min.	\$3.38
Respite RN	T1005	T1005RN	15 min.	\$10.90
Respite LPN	T1005	T1005LPN	15 min.	\$6.79
Respite HH Aide	T1005	T1005HHA	15 min.	\$4.08
Emergency Response (monthly fee)	S5161	S5161	Each	\$36.71-\$40.79
Emergency Response (testing and maintenance)	S5160	S5160	Each	As approved by MCO



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Environmental Modifications	S5165	S5165	Each	As approved by MCO (maximum of \$5,000 every 5 years)
Transportation Mile	T2049	T2049	Per Mile	\$0.34-\$0.40
Transportation Commercial Carrier Pass	T2004	T2004	Each	As approved by MCO
Start Up-Goods	T2028	T2028	Each	As approved by MCO
Fees and Memberships	T1999	T1999CP-I	Each	As approved by MCO
Coaching/education for parents, spouse or others (not available for paid caregivers)	T1999	T1999CE-I	Each	As approved by MCO
Coaching/education for parents, spouse or others <u>classes only</u> (not available for paid caregivers)	T1999	T1999CL-I	Each	As approved by MCO
Coaching/education for parents, spouse or others <u>conferences and seminars</u> (not available for paid caregivers)	T1999	T1999CS-I	Each	As approved by MCO
Technology for Safety and Independence	T1999	T1999TS	Each	As approved by MCO
Cell phone service (including data/GPS)	T1999	T1999CELL	Each	\$0.00-\$100.00
Cell phone and related equipment	T1999	T1999CPEP	Each	As approved by MCO
Cell phone/landline	T1999	T1999CPL	Each	As approved by MCO
Internet service	T1999	T1999IS	Each	As approved by MCO
Landline service	T1999	T1999LS	Each	As approved by MCO
Internet/cell phone	T1999	T1999IC	Each	As approved by MCO
Internet/cell phone/landline	T1999	T1999ICL	Each	As approved by MCO
Internet/landline	T1999	T1999IL	Each	As approved by MCO
Fax machine	T1999	T1999FX	Each	As approved by MCO
Computer	T1999	T1999CR	Each	As approved by MCO



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Office supplies	T1999	T1999OS	Each	As approved by MCO
Printer	T1999	T1999PR	Each	As approved by MCO
Health-related equipment and supplies	T1999	T1999HR-I	Each	As approved by MCO
Adaptive equipment and supplies	T1999	T1999AE-I	Each	As approved by MCO
Exercise equipment and related items	T1999	T199EE-I	Each	As approved by MCO
Nutritional supplements	T1999	T1999NS-I	Each	As approved by MCO
OTC medications	T1999	T1999OM-I	Each	As approved by MCO
Household related goods	T1999	T1999HG-I	Each	As approved by MCO
Appliances for independence	T1999	T1999AI-I	Each	As approved by MCO
Adaptive furniture	T1999	T1999AF-I	Each	As approved by MCO



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

9.22.2. SDCB Vendor Credentialing Requirements

Requirements for enrolling SDCB Vendors

Before using any Vendor, please call Conduent (1-866-916-0310) to ensure all required vendor paperwork has been processed and 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 DOS.

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

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

Vendors (Independent Contractors and Agencies) that provide Services Ag = Agency, IC = Independent Contractor				
Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
97810	Acupuncture <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Acupuncture and/or oriental medicine license



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services
 Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
H2019	Behavior Support Consultation <u>Allowed Providers:</u> Individual BSC or BSC Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Licensed (MD, Clinical Psychologist, Psychologist Associate, SW, LPCC, LPC, Psychiatric Nurse, New Mexico LMFT, New Mexico LPAT)
90901	Biofeedback <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: License in Health Care Profession whose scope of practice includes Biofeedback
98940	Chiropractic <u>Allowed Providers:</u> Group Practice or Individual Chiropractor	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Chiropractic Physician License
98940	Chiropractic <u>Allowed Providers:</u> Group Practice or Individual Chiropractor	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Chiropractic Physician License
T1999CE-I	Coaching Education for Parents, Spouse or Other <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1999CS-I	Coaching Education for Parents/Spouse: Conferences and Seminars ONLY <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999CL-I	Coaching Education for Parents/Spouse: Classes ONLY <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
97532	Cognitive Rehabilitation Therapy <u>Allowed Providers:</u> Group practice or Individual Specialized Therapist	Per 15 min	Agency: IC: Yes	Agency: Business License IC: License in Health Care Profession whose scope of practice includes Cognitive Rehabilitation Therapy
S5100	Customized Community Support <u>Allowed Providers:</u> Adult Day Health Agency or Adult Day Habilitation Agency	Per 15 min	Agency:	Agency: Business License
S5160	Emergency Response Testing and Maintenance <u>Allowed Providers:</u> Emergency Response Provider (Agency)	Each	Agency:	Agency: Business License



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services Ag = Agency, IC = Independent Contractor				
Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
S5161	Emergency Response Monthly Service Fee <u>Allowed Providers:</u> Emergency Response Provider (Agency)	Monthly	Agency:	Agency: Business License
T2019	Employment Supports (includes Job Coach) <u>Allowed Providers:</u> Supported Employment Provider Agency or Individual	Each	Agency: IC: Yes	Agency: Business License IC: Pre-Hire Packet
S5165	Environmental Modifications <u>Allowed Providers:</u> Individual or Company (Agency)	Each	Agency: IC: Yes	Agency: Appropriate License IC: Appropriate License
T1999CP-I	Fees and Memberships <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
T1999HR-I	Health-Related Equipment and Supplies <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
T1999AE-I	Adaptive Equipment and Supplies <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
T1999EE-I	Exercise Equipment and Related Items <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
T1999NS-I	Nutritional Supplements <u>Allowed Providers:</u> Vendor	Each	Agency: IC: Yes	VIF is required (goods only)
T1999OM-I	OTC Medications <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
S8940	Hippotherapy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: License in Healthcare profession whose scope of practice includes Hippotherapy.
S9122	Home Health Aide <u>Allowed Providers:</u> HHA/PCS Agency	Hour	Agency: Yes	Agency: Business License
99509	Self-Directed Personal Care <u>Allowed Providers:</u> Individual Self-Directed Personal Care Provider or HHA/PCS Agency	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services Ag = Agency, IC = Independent Contractor				
Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T1999HG-H	Household Related Goods and Services Hourly <u>Allowed</u> <u>Providers:</u> Vendor	Hourly	Agency: Yes IC: Yes	VIF is required (goods only)
T1999HG-I	Household Related Goods and Services Item/Invoice <u>Allowed</u> <u>Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999AI-I	Appliances for Independence Item/Invoice <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999AF-I	Adaptive Furniture Item/Invoice <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T2019JD	Job Developer <u>Allowed Providers:</u> Supported Employment Provider Agency or Individual	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
97124	Massage Therapy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Massage Therapist License
S8990	Naprapathy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Naprapathic Physician License
S9445	Native American Healers <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Session	Agency: Yes IC: Yes	IC: Pre-Hire Packet
S9470	Nutritional Counseling <u>Allowed Providers:</u> Group Practice or Individual	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Registered Dietician License
G0152	Occupational Therapy <u>Allowed Providers:</u> Individual Occupational Therapist or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: OT License



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services
 Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
G0151	Physical Therapy <u>Allowed Providers:</u> Group Practice or Individual Physical Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: PT License
H2032	Play Therapy <u>Allowed Providers:</u> Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Licensure in a MH profession whose scope of practice includes play therapy
T1003	Private Duty Nursing LPN <u>Allowed Providers:</u> HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1002	Private Duty Nursing RN <u>Allowed Providers:</u> HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T1005HHA	Respite Home Health Aide <u>Allowed Providers:</u> Respite Agency	Per 15 min	Agency: Yes IC: Yes	Agency: Business License
T1005SD	Respite Standard <u>Allowed Providers:</u> Individual Provider (not RN, LPN or HHA) or Respite Provider Agency	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1005LPN	Respite LPN <u>Allowed Providers:</u> Respite Provider Agency or Individual LPN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1005RN	Respite RN <u>Allowed Providers:</u> Respite Provider Agency or Individual RN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
G0153	Speech/Language Pathology <u>Allowed Providers:</u> Individual SLP or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T2028	Start-Up Goods <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services
 Ag = Agency, IC = Independent Contractor

Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T1999TS	Technology for Safety and Independence <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999CR	Computer Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999PR	Printer Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999FX	Fax Machine Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999CPEP	Cell Phone and Related Equipment Purchase (item) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999IS	Internet Service <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999CELL	Cell Phone Service <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999LS	Landline Service <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999ICL	Internet/Cell Phone/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999IC	Internet/Cell Phone Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999IL	Internet/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999CPL	Cell Phone/Landline Service (bundled) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)
T1999OS	Office Supplies (purchased as items) <u>Allowed Providers:</u> Vendor	Each	Agency: Yes IC: Yes	VIF is required (goods only)



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Vendors (Independent Contractors and Agencies) that provide Services Ag = Agency, IC = Independent Contractor				
Service Code	Service Code Description	Billing Method	Vendor Packet	License and/or Additional Requirements
T2004	Transportation Commercial Carrier Pass <u>Allowed Providers:</u> Transportation Commercial Carrier	Each	Agency: Yes IC: Yes	VIF is required (goods only)
	<u>Allowed Providers:</u> Transportation Agency or Individual Driver	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Transportation Appendix, Pre-Hire Packet
	<u>Allowed Providers:</u> Transportation Agency or Individual Driver	Each	Agency: Yes IC: Yes	Agency: Business License IC: Transportation Appendix, Pre-Hire Packet
T2049	Transportation Mile <u>Allowed Providers:</u> Transportation Agency or Individual Driver	Per Mile	Agency: Yes IC: Yes	Agency: Business License IC: Transportation Appendix, Pre-Hire Packet

If the vendor has a professional license (such as an RN or therapist), their licensing board has already completed a background check. Provider agencies are responsible for completing CBC on all their staff. Confirmation of the CBC must be available to the State and Conduent 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 Conduent 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 Conduent (1-866-916-0310) before your new SDCB Care Plan starts to ensure 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 Conduent (1-866-916-0310) or your Support Broker if you have any questions.

 HUMAN SERVICES DEPARTMENT	Section 9: Self-Directed Community Benefit	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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9.22.3 Employee Credentialing Requirements Grid

SELF-DIRECTED COMMUNITY BENEFIT SERVICE	Service Code	*Pre-Hire Packet	**Employee Packet	Transportation Appendix
Employment Supports (includes Job Coach)	T2019	Yes	Yes	No
Self-Directed Personal Care	99509	Yes	Yes	No
Respite – Standard	T1005SD	Yes	Yes	No
Transportation Mile	T2049	Yes	Yes	Yes

***Pre-Hire Packet:** Division of Health Improvement (DHI) form, copy of identification card, 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 Conduent does not receive



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

an Employee Agreement before the beginning of the new Plan, the employee may not get paid on time.



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

9.22.4. Vendor Toolkit: Invoices



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! Members, Employers and Vendors can work together to help make sure invoices get processed and paid on time.

Keys to Getting Paid the Correct Amount, On Time!

Follow these tips to avoid delayed payment of your invoice.

- **Be sure ALL vendor paperwork has been completed and submitted.**
- **Effective July 15, 2011, invoices that are received by Conduent (formerly Xerox) more than 90 days after the service was provided, will not be processed for payment.** According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the vendor performed the service. This means that all invoices with a PRF, must be submitted to Conduent no later than midnight on the 90th day after services have taken place. Any invoices with a PRF that are submitted after this time limit will not be paid by Conduent and will be returned to you. Also, if you need to make corrections to your invoice and/or PRF, 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 and PRF 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 and PRF!**
- 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 and PRFs for monthly service codes after the service is complete.**

If the service is monthly, you must wait until after midnight 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 invoice and PRF 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**



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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**

Corrections to an invoice cannot be handwritten unless the invoice to be corrected is handwritten. 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 PRF**

The PRF must also be submitted (in addition to the invoice). This applies whether it is you or the Employer who typically sends in the PRF and invoice. (The Employer is responsible for making sure that the PRF and invoice are sent in.)

- **Fax your invoice.**

Only fax your PRF and 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 PRF and invoice or forgetting to check the "Corrected" box on the PRF for a corrected invoice will cause delays in a check being issued. **The fax number is 1-866-302-6787.** This applies whether it is you or the Employer who typically faxes in the invoice (the Employer is responsible for making sure the PRF and invoice are faxed in.



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Invoice for Non-Timesheet Provider Agency/Contractor

FAX: 1-866-302-6787

MAIL: CONDUENT PO Box 27460, Albuquerque, NM 87125

Provider Agency/Contractor Dr. John Doe Is this a correction to a PRIOR invoice? Yes No

Date of Invoice (mm/dd/yyyy) 04/29/2011 Total Invoice \$ 81.06 (must match total \$ below)

Member Name: Pauline Participant Member Date of Birth: 01/01/1975

Date	Service Code	Hours per Day*	Rate per Hour*	Rate per Unit**	# of Units**	Total Charge	What Service(s) were provided? Be specific.	Member present?
4/25/11	G0151			\$13.51	4	\$54.04	Physical therapy	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
4/28/11	G0151			\$13.51	2	\$27.02	Physical therapy	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
Total Hours			Total Units/Charge		6	\$81.06		

This is the date the service was performed.

Use your Plan to verify the correct service code

The Total Charge should always equal the # of Units x Rate

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

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

Provider/Vendor Signature: Dr. John Doe Date 04/29/2011

Make sure the vendor signs here

Signature date must be on or after the last service date.

Date	SVC Code	Hrs per Day	Rate per Hour	Rate per Unit	Units per Day	Total Charge	What Service(s) were provided? Be specific.	Member present?
04-25-11	S9470	4	12.00			\$48.00	Nutritional Counseling	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
04-26-11	T2049			0.034	50	\$17.00	Mileage to the community center and back home.	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
04-27-11	T2033			25.00	1	\$25.00	Customized In-Home Living Support	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N
Total Hours		4	Total Units		51	\$90.00		



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014



9.22.5. Employee Toolkit: Timesheets

Toolkit: Timesheets

Q: What is this toolkit for?

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

TIPS FOR GETTING PAYCHECKS THAT ARE ACCURATE AND ON TIME!

- **Be sure ALL employee paperwork has been completed & submitted.**
- **Effective July 15, 2011, timesheets that are received by Conduent (formerly Xerox) more than 90 days after the service was provided will not be processed for payment.** According to Medicaid timely-filing requirements, we cannot process any request for payment that has not been submitted within 90 days from the date the employee worked. This means that all timesheets must be submitted to Conduent (via fax or the FOCoSonline system) no later than Midnight on the 90th day after services have taken place. Any timesheets that are submitted after this time limit will not be paid by Conduent and will be returned to you.

Also, if you need to make corrections to your timesheets, you must complete them within this timeframe (90 days from the date the employee worked).

- **Follow the CURRENT payroll periods.**

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

Note: For Employers that have been approved by the MCO for online timesheet exceptions, the deadline for submitting timesheets by fax is always on the Saturday by Midnight (before 12:00 am on Sunday) at the end of the pay period. Online timesheets must be approved in FOCoSonline by the Employer by 12:00 pm (noon) Tuesday after the end of the pay period.

- **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 member.

- **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 if you are on the MCO approved exception list.**

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 1-866-302-6787.**

- **Use the exact same name on your timesheet as used for your employee paperwork.**



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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



Section 9: Self-Directed Community Benefit

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

2-Week Self-Direction Timesheet for Payment

FAX 1-866-302-6787

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

Employee Name: Ellie Employee				Employee ID# (last 4 digits of employee's social security #) 1234		
Member/Participant: Pauline Participant				Is this a correction to a PRIOR Timesheet? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Member/Participant's Date of Birth: 1/4/57				Begin Date: 05/07/2011	End Date: 05/20/2011	
Date	Time In Circle AM or PM	Time Out Circle AM or PM	Hours	Service Code	Services Provided (Please enter)	
Week 1	05/07/2011	AM 8:00	PM 11:00	3	99509	Prepared meals, shopped for groceries.
	05/08/2011	AM 8:00	PM 11:00	3	99509	Picked up Pauline's prescriptions at pharmacy, helped her with laundry.
	05/09/2011	AM 8:00	PM 11:00	3	99509	Helped Pauline pack for trip to visit brother.
	05/10/2011	AM 2:00	PM 8:00	6	H2021	Took Pauline to event at library.
	05/10/2011	AM 10:00	PM 12:00	2	99509	Cleaned apartment.
	05/11/2011	AM 12:00	PM 1:00	1	99509	Prepared meals for next week.
Midnight Rule 10PM-12AM (1 st day) 12AM-1AM (2 nd day)						
Total Hours for Week 1 →			18	Must not be over 40		
Week 2	05/14/2011	AM 10:00	PM 12:00	2	99509	Laundry, cleaned apartment.
	05/15/2011	AM 12:00	PM 3:00	3	99509	Teach Pauline how to use computer.
	05/16/2011	AM 2:00	PM 8:00	6	99509	Worked with Pauline on practicing better safety skills at home.
	05/17/2011	AM 8:00	PM 4:00	8	99509	Worked with Pauline on washing dishes and cleaning the apartment.
	05/18/2011	AM 8:00	PM 1:00	5	99509	Prepared frozen meals for next week.
	Total Hours for Week 2 →			24	Must not be over 40	
Total Hours for Timesheet (2 weeks) →			42	Must not be over 80		

Service Dates must be on or within Begin and End Dates

Split Shift
8AM – 11AM Homemaker/Direct Support Services
2PM – 8PM Community Direct Support/Navigation

Ellie Employee
Employee Signature
Ellie Employee
Employee Printed Name

5/21/2011
Date

Pauline Participant
Employer Signature
Pauline Participant
Employer Printed Name

5/21/11
Date

Signed & dated on or after last service date

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 10: RESERVED	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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10. RESERVED



Section 11: Marketing

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

Effective dates: January 1, 2014

11. Marketing

11.1. General Information

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.

Definitions

Health Education: Programs, services or promotions designed or intended to advise or inform the MCO's 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 designed, intended, or used for health education or outreach to the MCO's enrolled members. Health education materials include, but are not limited to: condition-specific brochures, letters or phone calls, member newsletters, posters and member handbooks.

Incentives: Items used to encourage behavior changes in the MCO's enrolled members or health promotion incentives used to motivate members to adopt a healthy life style and/or obtain specific health care services. These may include but are not limited to:

- Infant car seats or baby item giveaways;
- Gift cards;
- Manufacturer or coupons for savings on products; or
- Services or any other objects designed or intended to be used in health education or outreach.

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

Marketing: Any medium of communication that is written, audio/oral, personal face-to-face, or electronic, including any promotional activities, intended to increase the MCO's or subcontractor's membership or to "brand" an MCO's or subcontractor's name or organization.

	Section 11: Marketing	Revision dates: August 15, 2014; March 3, 2015 Effective dates: January 1, 2014
---	------------------------------	---

Marketing Materials: General audience materials such as general circulation of brochures, flyers, newspaper, phone book advertisements, websites and/or any other materials designed, intended, or used for increasing the MCO's or subcontractor's membership or establishing a brand. Such marketing materials may include but are not limited to scripts, provider directories, leaflets, posters, billboards, or any material that is distributed or circulated by the MCOs and subcontractors, including providers (e.g., personal care providers).

Outreach: Any means of educating or informing the MCO's enrolled members about health issues. See also Health Education.

Outreach Materials: Materials designed, intended, or used for health education or outreach purposes only for the MCO's enrolled members. See also Health Education.

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


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

Policy

Marketing is 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 deemed eligible for services through Centennial Care.

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

The MCO must submit marketing, outreach, retention activities and materials to HSD for review and prior approval. In addition, the MCO must provide HSD with an electronic copy of the approved materials, advertising copy or publication in which the ad will be placed. All member materials must be mailed to members unless the member requests the material in an alternative format.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 11: Marketing</p>	<p>Revision dates: August 15, 2014; March 3, 2015</p> <p>Effective dates: January 1, 2014</p>
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- **Marketing Material Approval**

The MCO shall submit electronic versions of all written materials that will be distributed to members (referred to as member materials) to HSD’s Communication and Education Bureau’s Marketing Coordinator and copy the HSD contract manager for review and approval. This includes but is not limited to member handbooks, provider directories, member newsletters, member identification 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.
- The HSD Marketing Committee will attempt to approve or deny marketing requests within 15 business days of the receipt of the complete request. The 15 business day timeframe for approval or denial shall only apply to the specific date of the initial submission. Modifications of any type would need to be resubmitted, which may delay approval.
- Prior to modifying approved member materials, 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.
- The use of any material, including those that pertain to incentives, marketing, outreach, and promotions must have prior approval from the HSD Marketing Committee.
- Materials that have been previously approved, but will be included in a specific activity must also be included in the MCO’s submission for review and approval by HSD.
- MCOs shall review all material on a regular basis and revise materials as necessary. Any revised or updated material previously approved must be submitted to HSD for approval.

- **HSD Review of MCO Materials**

The MCO shall ensure all materials submitted to HSD for review meet the following criteria:




Section 11: Marketing

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

Effective dates: January 1, 2014

- 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;
- All materials consisting of two or more pages must be numbered;
- 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.;
- All materials must indicate if a translated version will be made available to the member or how the member can request a translated version;
- 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 business days for review and approval or request special accommodations for unique circumstances;
- 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, PowerPoint presentations, etc.). If MCOs are collaborating and conducting one training using the same PowerPoint presentation, one MCO should be designated to submit the material on behalf of all MCOs (e.g. Annual Tribal Meetings);
- All materials shall identify the MCO as an HSD/MAD managed care provider and are consistent with all the requirements for information to members described in the Agreement, regulations and the Manual;
- All materials shall specify “Such services are funded in part with the State of New Mexico”;
- All related materials should be submitted to HSD for review together, in lieu of separate submissions;
- All approved materials shall be provided in electronic format to the HSD marketing coordinator in the English and translated Spanish version (if applicable); and
- 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

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 11: Marketing</p>	<p>Revision dates: August 15, 2014; March 3, 2015</p> <p>Effective dates: January 1, 2014</p>
--	-------------------------------------	---

using such language in any of the materials, the request for approval must include how the message is related to an Outreach goal.

- **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 manned booth at the event, financially contributing to the event, and/or having a presence at the event.

- **Marketing and Outreach Plan**

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

- **MCO Health Plan Name and Logos**


MCO Name and Logos can be included on event flyers or websites that are produced by hosting organizations without prior approval. MCO must monitor their MCO name and logo use to prevent misuse. Small giveaway items such as, but not limited to, pens, pencils, balls, toys, etc. that are only identified by the addition of the MCO's logo do not need prior approval from HSD.

Any items that include the MCO's logo as well as any reference to Centennial Care or the State Medicaid program must be approved by HSD through the Marketing approval process.

- **Restrictions**

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

- 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);

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 11: Marketing</p>	<p>Revision dates: August 15, 2014; March 3, 2015</p> <p>Effective dates: January 1, 2014</p>
--	-------------------------------------	---

- Solicitation of any individual face-to-face, door-to-door or cold call telemarketing, including that of the MCO's subcontractors;
- Any reference to competing plans;
- Promotional materials, incentives, or any other activity to influence enrollment in conjunction with the sale or offering of any private insurance;
- Unsolicited direct mail advertising, including that of the MCO's subcontractors;
- Marketing of non-covered services;
- Reference to the word "free" for any covered service;
- Use of HSD/MAD logo;
- Inaccurate, misleading, confusing, or negative information about HSD, or statements designed to recruit potential members, including that of the MCO's subcontractors;
- Discriminatory marketing practices; and/or
- The MCO may not encourage or persuade the member to select a particular MCO plan or subcontracted provider when completing specific applications or forms. The MCO or its subcontractor may not complete any portion of the application forms on behalf of the potential enrollee. The prohibition covers all situations, whether sponsored by the MCO, its parent company, or any other entity.


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

- **Sanctions/Penalties**

Any violation of this policy may result in the sanctions as described in 7.3 of the Agreement.

The MCO shall ensure subcontractors are advised that they must comply with this policy. All materials must be submitted by all subcontractors to the MCO for review and approval based on the MCO specific policies and procedures for marketing.

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

	Section 11: Marketing	Revision dates: August 15, 2014; March 3, 2015 Effective dates: January 1, 2014
---	------------------------------	---

Subcontractors may only advertise the services they provide and may not make any reference to HSD/MAD programs, Medicaid or services the MCO provides.

- Temporary Sanctions/Penalties

Any activities or materials found in violation of this policy will be subject to sanction regardless of previous approval or terms in contractual agreements. The MCO contractor will be placed on “Moratorium” status and will not be allowed to advertise via the following:

- Television advertising;
- Internet advertising;
- Print advertising;
- Radio advertising;
- Billboards; and
- Bus wraps (including bus stops).

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

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

● **References**

- 42 CFR 438.104, 42 CFR 438.10, 42 CFR 431.12, 42 CFR 431.307
- HSD/MAD Medicaid Managed Care Services Agreement

	Section 12: Patient Centered Initiatives	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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12. Patient-Centered Initiatives

12.1. Broad Standards

The MCO shall establish patient-centered initiatives based on the National Committee for Quality (NCQA), Joint Commission on Accreditation of Healthcare Organizations, (JCAHO/JCAHO) or Accreditation Association for Ambulatory Health Care (AAAHC) PCMH recognition programs.

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

This model will be a blended model building upon the work already completed by practices that have achieved certification programs. A blended model will include a pathway toward certification for those practices that do not currently have the capacity to attain certification.

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

Core components of the New Mexico PCMH Model include:

- Administrative:
 - Adopt a standard model for PCMH that includes national certification by NCQA, AAAHC, and JCAHO;
 - Develop a “Glide Path” to certification that is open to all practices seeking PCMH status;
 - Provide technical assistance and hands on training for practices working towards PCMH certification; and
 - Simplify, coordinate and standardize practices across MCOs specifically: claims, prior authorizations, and other administrative processes.



Section 12: Patient Centered Initiatives

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- **Clinical:**
 - Improved access to care through flexible scheduling, accommodating walk-ins, utilization of telemedicine, providing after hours and weekend office hours;
 - Provider teams collaborate with community health workers, lactation consultants, public health workers, and other community members;
 - Integration/co-location of BH services, MH, and substance use including SBIRT;
 - Include school-based health centers and other non-traditional healthcare settings; and
 - Engage patients in their own health care decisions, respect for patient values, and culture and inclusion of patient care givers.
- **Coordination of care:**
 - Develop a care coordination collaborative that operates across payers at the point of care (in the health care office or other community location);
 - Prioritize communities of highest need;
 - Address social determinants of health (i.e., housing, food, transportation, etc.);
 - Seamless transition between services and providers; and
 - Integration of public health services, including but not limited to: Children's Medical Services care coordination for children with special health care needs, Women Infants and Children, sexually transmitted infection (STI) treatment, and contact tracing, etc.
- **Data:**
 - Build provider capacity through support for evidence-based programs;
 - Facilitate partnerships with supporting entities such as the Primary Care Association to help develop tools for providers;
 - Facilitate data sharing that provides optimal use of data for improving member outcomes; and
 - Commitment to data integration and sharing information to improve collaborative efforts to improve quality and lower costs, and to improve population health.




Section 12: Patient Centered Initiatives

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Payment:
 - While the MCO is not required to enter into VBP reimbursement arrangements with PCMHs, the MCOs are expected to implement VBP strategies to promote quality and improve health care outcomes in alignment with the Centennial Care contractual requirements;
 - Align value-based payments with patient health care outcomes and achievement of quality metrics; and
 - Standardize a payment approach for PCMH that includes practices that have not yet attained certification but are working on improving quality, access, and other core components of PCMH.
- Specific Actions Related to Policy:
 - Support Tribal 638 programs to become FQHCs under 330.


	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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13. ABP Medically Frail and ABP Exempt

13.1. General Information

This section of the Manual is issued to address the criteria and process for determining whether a member in the Other Adult Group COE 100 is medically frail. A medically frail member in COE 100 may choose to continue receiving services under the 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 (as defined in Section 13.2. of the Manual) 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 HSD Medicaid eligibility notice. The eligibility notice also directs ABP recipients to the HSD/MAD website where they can find the full listing of ABP benefits and a comparison to the Medicaid State Plan. This section of the 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.

	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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13.2. Determination of Medically Frail Diagnosis

Members in COE 100 may self-identify to the MCO by telephone that 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 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, the MCO should issue a 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.

	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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13.3. 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 an SMI, substance use disorder [SUD], or other mental disability) or PH (for a PH 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, a request may be sent to HSD/MAD to include the condition. The HSD/MAD Medical Director will review the request to determine whether the individual's condition should be added.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 13: Alternative Benefit Package</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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13.4. Appendices

13.4.1 ABP Benefit Chart

13.4.2 Alternative Benefit Plan-Exempt Medically Frail Conditions List

13.4.3 Chronic Substance Use Disorder (SUD) Criteria Checklist

13.4.4 Serious Mental Illness (SMI) Criteria Checklist

13.4.5 SMI-SED Criteria



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

13.4.1. ABP Benefit Chart

Medicaid ABP 1-8-2014

Recipient Definitions

Note there are 2 types of ABP recipients. The ABP recipient: The recipient is COE 100, but does not have a disability indicator of PH or ME. The charts below are only applicable to the ABP recipient category.

ABP Exempt: The recipient is COE 100 but also has a disability indicator of PH or ME, meaning either a PH or MH 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.

The COE of the recipient remains 100 with a PH or ME indicator to distinguish them in the various computer systems. **Because the benefits of an ABP-Exempt recipient become the same as any other standard full benefit Medicaid recipient, we do not list their benefits in this chart.**

The term "ABP recipient" always means an ABP recipient who is **not** ABP exempt. If the recipient is exempt (and therefore eligible for the standard Medicaid full benefit services) the recipient is always referred to as an "ABP Exempt recipient".

Once the recipient becomes an ABP Exempt recipient, they are **not** subject to any of the service limits associated with ABP. They do not retain any of the additional services 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 provided to the full benefit Medicaid recipient.

An ABP Recipient has the following benefits equivalent to those of standard Medicaid Benefits: professional services and treatments, including services at FQHC's and other clinics; inpatient and outpatient hospital services; equipment and devices; laboratory and radiology; and



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

transportation).

The coverage of the following services or providers of services under the ABP is essentially the same that for the standard Medicaid full benefit population and, therefore, would be covered by an MCO to the same extent an MCO covers and provides services to traditional full Medicaid eligible recipients. The list is intended to be used to communicate the general scope of the services. Not every provider and service is described:

- Physician and most practitioner services and visits, including maternity service, surgeries, anesthesia, podiatry, etc., that are available for traditional full Medicaid eligible recipients;
- BH and substance abuse services, evaluations, assessments, therapies, including all the various forms of therapy such as Comprehensive Community Support Services that are available for traditional full Medicaid eligible recipients:
 - Specialized BH services for children: the MCO must ensure BH and substance abuse services provided to EPSDT recipients are available to ABP recipients ages 19 and 20;
 - Specialized BH services for adults: The specialized BH services for adults are Intensive Outpatient, Assertive Community Treatment, and Psychosocial Rehabilitation. These three services are included in the ABP;
 - Services not included in the ABP: The following services are not included in the ABP plan because they are considered more in the area of supportive waiver-type services and are not State Plan services: Family Support, Recovery Services, and Respite Services; and
 - Electroconvulsive therapy: This is a benefit under ABP, but **not** as a State Plan service for standard service.
- Cancer trials, chemotherapy, IV infusions, and reconstructive surgery services that are available for traditional full Medicaid eligible recipients;
- 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;



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Diabetes treatment including diabetic shoes;
- Dialysis;
- DME, 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;
- Family planning, sterilization, pregnancy termination, contraceptives;
- Hearing testing or screening as part of a routine health exam. ABP does **not** cover the hearing aids and does 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;
- Hospice services — If the hospice recipient requires NF LOC, the recipient will have to meet the requirements for receiving NF care;
- Hospital inpatient, outpatient, urgent care, emergency department, outpatient free-standing psychiatric hospitals, inpatient units in acute care hospitals for rehabilitation or psychiatric, and rehabilitation specialty hospitals:
 - Free-standing psychiatric hospitals are only covered for EPSDT children (therefore, up through age 20) for FFS recipients. However, MCOs continue to pay for inpatient free-standing psychiatric hospitals for adults; and
 - Inpatient drug rehabilitation services are not an ABP benefit. Acute inpatient services for “detox” are an ABP covered benefit.
- Immunizations, mammography, colorectal cancer screenings, pap smears, prostate-specific antigen (PSA) tests, and other age appropriate tests that are available for traditional full Medicaid eligible recipients;
- Inhalation therapy;
- 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;



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Lab genetic testing to specific molecular lab tests such as breast cancer susceptibility gene (BRCA)1 and BRCA2 and similar tests used to determine appropriate treatment, not including random genetic screening;
- Medication assisted treatment (substance abuse treatment including methadone programs, naloxone, and suboxone);
- Ob-gyn, prenatal care, deliveries, midwives;
- Orthotics (note foot orthotics including shoes and arch supports are only covered when an integral part of a leg brace, or are diabetic shoes);
- Podiatry services are available to the same extent as for traditional full Medicaid eligible recipients. (coverage is similar to Medicare);
- Prescription drug items (but not over the counter [OTC] items, except for prenatal drug items (examples include 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);
- Prosthetics are available to the same extent as for traditional full Medicaid eligible recipients;
- Radiology including diagnostic imaging and radiation therapy, including mammography and other age appropriate imagining;
- Reproductive health services are available to the same extent as for traditional full Medicaid eligible recipients;
- Telemedicine;
- Tobacco cessation counseling that are available for traditional full Medicaid eligible recipients. MCOs must cover tobacco cessation counseling beyond the Medicaid FFS coverage; and
- Transportation (emergency and non-emergency) including air and ground ambulance, taxi and handivan.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

The following services are **not** covered under the standard Medicaid benefits or the ABP and are not required to be covered by the MCO for ABP members unless the MCO chooses to do so as VAS.

- Acupuncture;
- Infertility treatment;
- Naprapathy;
- Temporomandibular joint and crania mandibular joint treatment;
- Weight loss programs; and
- Any other service not covered by the standard Medicaid program unless specifically described as an added benefit for ABP in this section.

Note also the ABP does **not** include the following:

- CBs;
- NF care, except as a temporary step down LOC from a hospital prior to being discharged to home; and
- Mi Via.

However, if an ABP recipient becomes an ABP Exempt recipient, the recipient can access CBs, NF care, and Mi Via when all the requirements to receive those services are met.

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.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	Limitations for ABP Recipients (COE 100) for Ages 21 And Above	For Ages 19 and 20 Limitations Do Not Apply to ABP Recipients (COE 100) Who Are Ages 19 or 20 Because of EPSDT Rules Recipients Under Age 19 Are Not Enrolled In ABP
Bariatric surgery	Limited to 1 per life time. Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.	Covered under EPSDT if medically necessary (perhaps unlikely) without the life time limit. Criteria may be applied that considers previous attempts by the recipient to lose
Cardiac rehabilitation	Limited to 36 hours per cardiac event.	Covered under EPSDT if medically necessary without the limit on hours.
Chiropractic	Not covered.	Covered under EPSDT if medically necessary (this very rarely happens).
Drug items that do not require a prescription (OTC)	Not covered except for items related to prenatal care; low dose aspirin for preventing cardiac events; treatment of diabetes, items used for contraception (foams, devices, etc.). Coverage of diabetic test strips, and similar items are described under medical supplies, below. An MCO may choose to cover any OTC product when the OTC product is less expensive than the therapeutically equivalent drug that would require a prescription (a	Covered using the same provisions as for recipient under EPSDT in the standard Medicaid program.
Glasses and contact lens	Not covered except for aphasia (following removal of the lens.) 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.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	Limitations for ABP Recipients (COE 100) for Ages 21 And Above	For Ages 19 and 20 Limitations Do Not Apply to ABP Recipients (COE 100) Who Are Ages 19 or 20 Because of EPSDT Rules Recipients Under Age 19 Are Not Enrolled In ABP
Hearing aids	<p>Not covered.</p> <p>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.</p> <p>Hearing testing by an audiologist or a hearing</p>	<p>Covered using the same provisions as for children under EPSDT in the standard Medicaid program.</p>
HH services	<p>Limited to 100 visits annually – a visit cannot exceed 4 hours.</p> <p>An MCO has the option of providing these services through private duty nursing and nursing registry personnel</p>	<p>Covered under EPSDT without the limitation on the dollar amount or length of visits.</p>
Medical foods for errors of inborn metabolism, or as a substitute for other food for weight gain, weight loss, or specialized diets, for use at home by a recipient.	<p>Not covered.</p>	<p>Covered using the same provisions as for children under EPSDT in the standard Medicaid program.</p> <p>May be subjected to criteria that assure medical necessity.</p>



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	Limitations for ABP Recipients (COE 100) for Ages 21 And Above	For Ages 19 and 20 Limitations Do Not Apply to ABP Recipients (COE 100) Who Are Ages 19 or 20 Because of EPSDT Rules Recipients Under Age 19 Are Not Enrolled In ABP
<p>Disposable medical supplies such as diapers, under pads, gauzes, gloves, dressings, colostomy supplies, for use at home by a recipient.</p>	<p>Not covered.</p> <p>Except for diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.).</p> <p>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.</p> <p>Medical supplies used on an inpatient basis, applied as part of a treatment in a practitioner's office, outpatient hospital, residential facilities, as a HH service, etc. are covered though often these items are not paid separately in addition to the payment for the overall service.</p> <p>When separate payment is allowed in these settings, the items are considered covered.</p>	<p>Covered using the same provisions as for children under EPSDT in the standard Medicaid program.</p> <p>May be subjected to criteria that assure medical necessity.</p>
<p>Pulmonary rehabilitation</p>	<p>Limited to 36 hours per year.</p>	<p>Covered under EPSDT without the limitation on the number of visits.</p>




Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	Limitations for ABP Recipients (COE 100) for Ages 21 And Above	For Ages 19 and 20 Limitations Do Not Apply to ABP Recipients (COE 100) Who Are Ages 19 or 20 Because of EPSDT Rules Recipients Under Age 19 Are Not Enrolled In ABP
Rehabilitation and Habilitation <ul style="list-style-type: none"> • PT • OT • SLP 	<p>Rehabilitative services for short-term physical, occupational, and speech therapies are covered.</p> <p>Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment.</p> <p>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.</p> <p>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.</p>	<p>Covered under EPSDT without the limitation on duration.</p>
Extended care hospitals (LTC hospitals)	<p>Extended care hospitals are not covered. Sometimes these are referred to as LTC hospitals (certified as acute care hospitals but focus on care for more than 25 days).</p> <p>NF LTC stays are not covered by ABP except as a temporary step down LOC following discharge from a hospital prior to being discharged to home.</p>	<p>Covered under EPSDT without the limitations.</p>

 HUMAN SERVICES DEPARTMENT	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	--	---

Service	Limitations for ABP Recipients (COE 100) for Ages 21 And Above	For Ages 19 and 20 Limitations Do Not Apply to ABP Recipients (COE 100) Who Are Ages 19 or 20 Because of EPSDT Rules Recipients Under Age 19 Are Not Enrolled In ABP
Sleep studies	Not covered.	Covered under EPSDT.
Transplants	Limited to 2 per lifetime.	Covered under EPSDT without the dollar amount limitation.

ABP benefits that may exceed the standard Medicaid Coverage are listed below. 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.

Service	Notes
Preventive care, annual physicals, etc.	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 at the end of this document.
Autism spectrum disorder	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 in New Mexico, the ABP plan also includes ages 21 and 22 for this benefit.
Disease management	
Electroconvulsive therapy	
Educational materials and counseling for a healthy life style	
Nutritional counseling	
Skilled nursing	Skilled nursing is generally provided only through a HH agency under the Medicaid FFS program. However, an MCO can also provide skilled nursing through private duty nursing.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Preventive care services, typical of what is found in a commercial insurance plan, are covered for ABP recipients. Typically, this includes annual exams with all the components appropriate for the age, condition, and history of the recipient as recommended by various physician specialty associations and academies.

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

The requirements related to ABP include assuring the ABP population’s preventive care benefits include the recommendations of the United States Preventive Services Task Force (USPSTF).

These recommendations are found at the following website:

<https://www.uspreventiveservicestaskforce.org/>

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

The following list includes items that may need special attention or comment, but we have removed items from the list that are routinely performed in hospitals at the time of birth (e.g., phenylketonuria screening), 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.

Service	USPSTF Recommendations	Application to Medicaid
Abdominal aortic aneurysm screening: men	One-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have never smoked.	Technically a new requirement, but Medicaid would not currently deny a claim for this service.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	USPSTF Recommendations	Application to Medicaid
Alcohol misuse: screening and counseling	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.	Technically a new requirement, but practitioners would already be performing this function during exams. The counseling component does not have to include any providers not currently covered by the Medicaid program.
Anemia screening: pregnant women	Routine screening for iron deficiency anemia in asymptomatic pregnant women.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Aspirin to prevent cardiovascular disease: men	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Aspirin to prevent cardiovascular disease: women	The use of aspirin for women ages 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Bacteriuria screening: pregnant women	Screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Blood pressure screening in adults	Screening for high blood pressure in adults age 18 years and older.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
BRCA screening, counseling about	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Breast cancer preventive medication	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	USPSTF Recommendations	Application to Medicaid
Breast cancer screening	Screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Breastfeeding counseling	Interventions during pregnancy and after birth to promote and support breastfeeding.	At this time, based on comparison with commercial plans MAD interprets this as instruction or counseling that would occur during the routine prenatal care and postpartum care; and possibly assessed for any issues or lack of success by the pediatrician treating the newborn.
Cervical cancer screening	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 testing every 5 years.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Chlamydial infection screening: non-pregnant women	Screening for chlamydial infection in all sexually active non-pregnant young women age 24 years and younger and for older non-pregnant women who are at increased risk.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Chlamydial infection screening: pregnant women	Screening for chlamydial infection in all pregnant women age 24 years and younger and for older pregnant women who are at increased risk.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: men 35 and older	Screening men age 35 years and older for lipid disorders.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: men younger than 35	Screening men ages 20 to 35 years for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Cholesterol abnormalities screening: women 45 and older	Screening women age 45 years and older for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	USPSTF Recommendations	Application to Medicaid
Cholesterol abnormalities screening: women younger than 45	Screening women ages 20 to 45 years for lipid disorders if they are at increased risk for coronary heart disease.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Colorectal cancer screening	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Depression screening: adults	Screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.	Covered – already in managed care coverage requirements. The “depression care supports” component does not have to include any provider types not currently covered by the Medicaid program.
Diabetes screening	Screening for Type 2 Diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Falls prevention in older adults: exercise or PT	Exercise or PT to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	At this time and 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 PT.
Falls prevention in older adults: vitamin D	Vitamin D supplementation to prevent falls in community- dwelling adults age 65 years and older who are at increased risk for falls.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Folic acid supplementation	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	USPSTF Recommendations	Application to Medicaid
Healthy diet counseling	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.	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
Hepatitis B screening: pregnant women	Screening for Hepatitis B virus infection in pregnant women at their first prenatal visit.	Technically a new, requirement, but good practitioners would already be performing this function during exams for high risk individuals.
Hepatitis C virus infection screening: adults	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.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
HIV screening: non-pregnant adolescents and adults	Clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
HIV screening: pregnant women	Clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
Intimate partner violence screening: women of childbearing age	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.	Technically a new requirement, but practitioners would already be performing this function during exams for high risk individuals.
Obesity screening and counseling: adults	Screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m ² or higher to intensive, multicomponent behavioral interventions.	Covered – already in managed care coverage requirements. May be performed by a physician, dietician, or other qualifying practitioner



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Service	USPSTF Recommendations	Application to Medicaid
Osteoporosis screening: women	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Rh incompatibility screening: first pregnancy visit	Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Rh incompatibility screening: 24–28 weeks' gestation	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.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
STI counseling	High-intensity behavioral counseling to prevent STIs in all sexually active adolescents and for adults at increased risk for STIs.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient State Plan service.
Skin cancer behavioral counseling	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.	Broader requirement than currently exists as a standard Medicaid recipient service.
Tobacco use counseling and interventions: non-pregnant adults	Clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.	Broader requirement than currently exists as a standard Medicaid recipient service.
Tobacco use counseling: pregnant women	Clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service.
Syphilis screening: non-pregnant persons	Clinicians screen persons at increased risk for syphilis infection.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service
Syphilis screening: pregnant women	Clinicians screen all pregnant women for syphilis infection.	Covered – already in managed care coverage requirements or as a standard Medicaid recipient service.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

13.4.2. 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 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.

- Acquired Immune Deficiency Syndrome (AIDS)
- ALS (Lou Gehrig's Disease)
- Angina Pectoris
- Arteriosclerosis Obliterans
- Artificial Heart Valve
- Ascites
- Blindness
- Cancer (current diagnosis/treatment, within five years)
- Cardiomyopathy
- Chronic Substance Use Disorder – refer to the Substance Use Disorder (SUD) Criteria effective August 2015 (or subsequent replacement version)
- Cirrhosis of the liver
- Compromised immune system
- Coronary insufficiency
- Coronary occlusion

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 13: Alternative Benefit Package</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- Crohn's disease
- Cystic Fibrosis
- Dermatomayositis
- Diabetes (Insulin Dependent)
- Disability: A physical, intellectual or developmental disability that significantly impairs the ability to perform one or more ADLs – refer to the NF LOC Supplement effective January 1, 2014 (or subsequent replacement version)
- Friedreich's Disease
- Hemophilia
- Hepatitis C (Active)
- HIV+
- Hodgkin's Disease
- Huntington's Chorea
- Hydrocephalus
- Intermittent Claudication
- Juvenile Diabetes
- Kidney failure
- Lead poisoning with cerebral involvement
- Leukemia
- Lupus Erythematosus Disseminate
- Malignant tumor (If treated/occurred within previous five years)
- Metastatic cancer
- Motor or sensory aphasia

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 13: Alternative Benefit Package</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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- Multiple or Disseminated Sclerosis
- Muscular Atrophy or Dystrophy
- Myasthenia Gravis
- Myotonia
- Open heart surgery
- Organ transplant
- Paraplegia or Quadriplegia
- Parkinson’s Disease
- Peripheral Arteriosclerosis (If treated within previous three years)
- Polyarthritis (Periarthritis 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

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	--	--

- Thalassemia (Cooley's or Mediterranean Anemia)
- Topectomy and Lobotomy
- Wilson's Disease

 HUMAN SERVICES DEPARTMENT	Section 13: Alternative Benefit Package	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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13.4.3. Chronic SUD Criteria Checklist

SUD Criteria	DSM-V	DSM-V	Description
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate, Severe
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate, Severe
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or unspecified stimulant
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine-type substance
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder- Other Hallucinogen Use
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder – Phencyclidine Use Disorder –
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders

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

HSD - March 2016.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

13.4.4. SMI Criteria Checklist

**Serious Mental Illness (SMI)
CRITERIA CHECKLIST**



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

- 1. **Age:** Must be an adult 18 years of age or older.
- 2. **Diagnoses:** Have one of the diagnoses as defined under the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders. The diagnosis would need to have been determined within the prior 12 months by an appropriately credentialed and licensed professional.
 - Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system BH services.
- 3. **Functional Impairment:** The disturbance is excessive and causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- 4. **Duration:**
 - The disability must be expected to persist for six months or longer.

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

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



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Person is experiencing trauma symptoms related to sexual assault, domestic violence or other traumatic event.

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



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

13.4.5. SMI-SED Criteria

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Neurodevelopmental Disorders	299.00	F84.0	Autism Spectrum Disorder
Neurodevelopmental Disorders	307.22	F95.1	Motor Disorder – persistent (chronic) motor or vocal tic
Neurodevelopmental Disorders	307.23	F95.2	Tourette’s Disorder
Neurodevelopmental Disorders	307.3	F98.4	Stereotypic Movement Disorder
Neurodevelopmental Disorders	314.00	F90.0	Attention Deficit/Hyperactivity Disorder (ADHD): Predominantly
Neurodevelopmental Disorders	314.01	F90.1	ADHD: Predominantly
Neurodevelopmental Disorders	314.01	F90.2	ADHD: Combined
Neurodevelopmental Disorders	314.01	F90.8	ADHD: Other Specified
Neurodevelopmental Disorders	314.01	F90.0	ADHD: Unidentified
Schizophrenia Spectrum and other Psychotic Disorders	293.81	F06.2	With delusions
Schizophrenia Spectrum and other Psychotic Disorders	293.82	F06.0	With hallucinations
Schizophrenia Spectrum and other Psychotic Disorders	295.40	F20.81	Schizophreniform Disorder
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.0	Bipolar type
Schizophrenia Spectrum and other Psychotic Disorders	295.70	F25.1	Depressive type
Schizophrenia Spectrum and other Psychotic Disorders	295.90	F20.9	Schizophrenia
Schizophrenia Spectrum and other Psychotic Disorders	297.1	F22	Delusional Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.8	F28	Other Specified Schizophrenia Spectrum and Other Psychotic
Schizophrenia Spectrum and other Psychotic Disorders	293.89	F06.01	Catatonia Associated with Another Mental Disorder
Schizophrenia Spectrum and other Psychotic Disorders	298.9	F29	Unspecified Schizophrenia Spectrum and Other Psychotic
Schizophrenia Spectrum and other Psychotic Disorders	301.22	F21	Schizotypal (Personality) Disorder
Bipolar and Related Disorders	293.83	F06.33	Bipolar and Related Disorders due to another medical condition. Specify.



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Bipolar and Related Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical
Bipolar and Related Disorders	296.40	F31.9	Unspecified
Bipolar and Related Disorders	296.41	F31.11	Mild
Bipolar and Related Disorders	296.42	F31.12	Moderate
Bipolar and Related Disorders	296.43	F31.13	Severe
Bipolar and Related Disorders	296.44	F31.2	With psychotic features
Bipolar and Related Disorders	296.45	F31.73	In partial remission
Bipolar and Related Disorders	296.46	F31.74	In full remission
Bipolar and Related Disorders	296.50	F31.9	Unspecified
Bipolar and Related Disorders	296.51	F31.31	Mild
Bipolar and Related Disorders	296.52	F31.32	Moderate
Bipolar and Related Disorders	296.53	F31.4	Severe
Bipolar and Related Disorders	296.54	F31.5	With psychotic features
Bipolar and Related Disorders	296.55	F31.75	In partial remission
Bipolar and Related Disorders	296.56	F31.76	In full remission
Bipolar and Related Disorders	296.89	F31.81	Bipolar II Disorder
Bipolar and Related Disorders	296.80	F31.9	Unspecified Bipolar and related disorder
Depressive Disorders	296.99	F34.8	Disruptive Mood Dysregulation Disorder
Depressive Disorders	293.83	F06.31	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	293.83	F06.32	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	293.83	F06.34	Bipolar and Related Disorders due to another medical condition
Depressive Disorders	296.20	F32.9	Unspecified



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Depressive Disorders	296.21	F32.0	Mild
Depressive Disorders	296.22	F32.1	Moderate
Depressive Disorders	296.23	F32.2	Severe
Depressive Disorders	296.24	F32.3	With psychotic features
Depressive Disorders	296.25	F32.4	In partial remission
Depressive Disorders	296.26	F32.5	In full remission
Depressive Disorders	296.30	F33.9	Unspecified
Depressive Disorders	296.31	F33.0	Mild
Depressive Disorders	296.32	F33.1	Moderate
Depressive Disorders	296.33	F33.2	Severe
Depressive Disorders	296.34	F33.3	With psychotic features
Depressive Disorders	296.35	F33.41	In partial remission
Depressive Disorders	296.36	F33.42	In full remission
Depressive Disorders	300.4	F34.1	Persistent Depressive Disorder
Depressive Disorders	311	F32.8	Other Specified Depressive Disorder
Depressive Disorders	311	F32.9	Unspecified Depressive Disorder
Depressive Disorders	625.4	N94.3	Premenstrual Dysphoric Disorder
Anxiety Disorders	293.84	F06.4	Anxiety Disorder due to another medical condition
Anxiety Disorders	300.00	F41.9	Unspecified Anxiety Disorder
Anxiety Disorders	300.01	F41.0	Panic Disorder
Anxiety Disorders	300.02	F41.1	Generalized Anxiety Disorder
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Anxiety Disorders	300.22	F40.00	Agoraphobia
Anxiety Disorders	300.23	F40.10	Social Anxiety Disorder (Social Phobia)
Anxiety Disorders	309.21	F93.0	Separation Anxiety Disorder
Obsessive-Compulsive Related Disorders	294.8	F06.8	Obsessive-Compulsive Disorder due to another medical condition
Obsessive-Compulsive Related Disorders	300.3	F42	Obsessive-Compulsive Disorder, Hoarding Disorder, Other Specified obsessive-Compulsive
Obsessive-Compulsive Related Disorders	300.7	F45.22	Body Dysmorphic Disorder
Obsessive-Compulsive Related Disorders	312.39	F63.3	Trichotillomania (Hair-Pulling Disorder)
Obsessive-Compulsive Related Disorders	698.4	L98.1	Excoriation (Skin-Picking) Disorder
Trauma-and Stressor Related Disorders	308.3	F43.0	Acute Stress Disorder
Trauma-and Stressor Related Disorders	309.0	F43.21	With depressed mood
Trauma-and Stressor Related Disorders	309.24	F43.22	With anxiety
Trauma-and Stressor Related Disorders	309.28	F43.23	With anxiety and depressed mood
Trauma-and Stressor Related Disorders	309.3	F43.24	With disturbance of conduct
Trauma-and Stressor Related Disorders	309.4	F43.25	With mixed disturbance of emotions
Trauma-and Stressor Related Disorders	309.81	F43.10	Posttraumatic Stress Disorder
Trauma-and Stressor Related Disorders	309.89	F43.8	Other specified trauma and stressor-related
Trauma-and Stressor Related Disorders	309.9	F43.9	Unspecified trauma and stressor-related
Trauma-and Stressor Related Disorders	313.89	F94.1	Trauma and stressor-related Disorder
Trauma-and Stressor Related Disorders	313.89	F94.2	Disinhibited Social Engagement Disorder
Dissociative Disorders	300.12	F44.0	Dissociative Amnesia
Dissociative Disorders	300.13	F44.1	With dissociative fugue



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Dissociative Disorders	300.14	F44.81	Dissociative Identity Disorder
Dissociative Disorders	300.15	F44.89	Other Specified Dissociative Disorder
Dissociative Disorders	300.15	F44.9	Unspecified Dissociative Disorder
Dissociative Disorders	300.6	F48.1	Depersonalization/Derealization Disorder
Somatic Symptom and Related Disorders	300.11	F44.4	Conversation Disorder (Functional Neurological Symptom Disorder. Specify: with weakness or paralysis; or with abnormal movement; or with swallowing symptoms
Somatic Symptom and Related Disorders	300.11	F44.5	Conversation Disorder (Functional Neurological Symptom) Disorder. Specify: With attacks of seizures; or with special sensory
Somatic Symptom and Related Disorders	300.11	F44.6	Conversation Disorder (Functional Neurological Symptom
Somatic Symptom and Related Disorders	300.11	F44.7	Conversation Disorder (Functional Neurological Symptom
Somatic Symptom and Related Disorders	300.19	F68.10	Factitious Disorder Imposed on Self, Factitious Disorder Imposed
Somatic Symptom and Related Disorders	300.7	F45.21	Illness Anxiety Disorder
Somatic Symptom and Related Disorders	300.82	F45.1	Somatic Symptom Disorder
Somatic Symptom and Related Disorders	300.89	F45.8	Other Specified Somatic Symptom and
Feeding and Eating Disorders	307.1	F50.01	Anorexia Nervosa – Restricting type
Feeding and Eating Disorders	307.1	F50.02	Anorexia Nervosa – Binge-eating/Purging
Feeding and Eating Disorders	307.50	F50.9	Unspecified Feeding and Eating Disorders
Feeding and Eating Disorders	307.51	F50.2 F50.8	Bulimia Nervosa (F50.2) Binge-eating Disorder (F50.)
Feeding and Eating Disorders	307.52	F98.3	In children
Feeding and Eating Disorders	307.52	F50.8	In adults
Disruptive, Impulse Control and Conduct	312.33	F63.1	Pyromania



Section 13: Alternative Benefit Package

Revision dates: August 15, 2014; March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

SMI-SED Category	DSM-V	DSM-V ICD-10	Description
Disruptive, Impulse Control and Conduct	312.34	F63.81	Intermittent Explosive Disorder
Disruptive, Impulse Control and Conduct	312.81	F91.1	Childhood-onset type
Disruptive, Impulse Control and Conduct	312.89	F91.8	Other Specified Disruptive Impulse
Disruptive, Impulse Control and Conduct	312.9	F91.9	Unspecified Disruptive, Impulse Control
Disruptive, Impulse Control and Conduct Disorders	313.81	F91.3	Oppositional Defiant Disorder – Specify current severity: Mild
Cyclothymic Disorder	301.13	F34.0	Cyclothymic Disorder
Persistent Depressive Disorder	300.4	F34.1	Persistent Depressive Disorder - Dysthymia
Personality Disorders [For which there is an evidence based clinical intervention available]	301.83	F60.3	Borderline Personality Disorder
Substance-Related and Addictive Disorders	292.9	F12.99	Unspecified Cannabis Abuse Disorder
Substance-Related and Addictive Disorders	303.90	F10.20	Alcohol Use Disorder – Moderate, Severe
Substance-Related and Addictive Disorders	304.00	F11.20	Opioid-Related Disorders – Moderate
Substance-Related and Addictive Disorders	304.20	F14.20	Stimulant-Related Disorder - Cocaine
Substance-Related and Addictive Disorders	304.30	F12.20	Cannabis- Related Disorder - Moderate
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Other or
Substance-Related and Addictive Disorders	304.40	F15.20	Stimulant-Related Disorder – Amphetamine
Substance-Related and Addictive Disorders	304.50	F16.20	Hallucinogen-Related Disorder – Other Hallucinogen Use
Substance-Related and Addictive Disorders	304.60	F16.20	Hallucinogen-Related Disorder – Phencyclidine Use Disorder –
Substance-Related and Addictive Disorders	304.90	F19.20	Other (or Unknown) Substance-Related and Addictive Disorders – moderate, severe

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

	Section 14: School-Based Health Centers	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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14. School-Based Health Centers

14.1. General Information

SBHCs are a vital part of the health care delivery system in New Mexico. SBHCs are comprehensive primary health care centers on or adjacent to school grounds that provide PH and BH services to students and community members. SBHCs also promote positive health behaviors and health care literacy by increasing health knowledge and decision-making skills in the students they serve. By offering a range of health care services in school settings, SBHCs simultaneously increase access to care and decrease the amount of classroom time missed by students leaving campus for care in traditional settings. As a result, SBHCs can positively impact academic participation as well as health outcomes.

The HSD/MAD supports SBHCs by providing Medicaid reimbursement through MCOs, to SBHCs and their medical providers for Medicaid eligible members as appropriate. A working partnership between Mexico Department of Health's, Office of School and Adolescent Health (DOH/OSAH) and HSD/MAD certify that SBHCs meet State quality standards. HSD/MAD contracts with DOH/OSAH for the provision of funding, leadership, support and oversight to SBHCs across New Mexico. SBHCs may choose to contract for those provisions through the New Mexico DOH/OSAH. SBHCs that do not wish to establish a contract with DOH/OSAH will follow regulations and policies applicable to their organization.

This policy uses the following terms which take on a unique application to the SBHC program.

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

SBHC Provider Type - SBHCs may apply for approval for HSD/MAD Certification for Medicaid billing as either a Provider Type 321 (SBHC) or Provider Type 313 (FQHC):

- Provider Type 313 – FQHC:

	Section 14: School-Based Health Centers	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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- This type of SBHC meets the definition of a SBHC according to Social Security Act Section 2110 (c) (9) and is certified by CMS as a FQHC. As a result, this type of SBHC meets State requirements of an eligible provider according to NMAC 8.302.1.10; and
- FQHC Sponsored SBHCs may also contract with the DOH/OSAH for the provision of funding, leadership, support and oversight.
- Provider Type 321 – Independent/Non-Medical Entity Sponsored Sites (i.e., non-profits, universities, hospitals):
 - This type of SBHC may also contract with DOH/OSAH for the provision of funding, leadership, support, and oversight.
 - SBHCs operating under provider type 321 must do so in collaboration with DOH/OSAH and HSD/MAD. Although the facilities are not licensed as required by the Medicaid General Provider Policy (NMAC 8.302.1.10) to meet the definition of an “eligible provider,” the sites participate under a limited scope of services they are also subject to the New Mexico Standards and Benchmarks for SBHCs and must pass a periodic on-site review conducted by DOH/OSAH.

DOH/OSAH and HSD/MAD will work collaboratively on program planning, policy development, interagency coordination, and education related to health care services, including primary care, BH, and dental services, provided by the SBHC and other SBHC programs as outlined in the agreement between DOH/OSAH and HSD/MAD.

An SBHC that would like to contract with DOH/OSAH must contact DOH/OSAH to initiate an initial Certification. Any SBHC site that experiences a lapse in eligibility validation or is an additional SBHC to the Sponsoring Entity is subject to the same process.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 14: School-Based Health Centers	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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14.2. Certification Process

Contact with DOH/OSAH will be made by interested SBHC and its sponsoring entity. DOH/OSAH will provide interested parties with Standards and Benchmarks, Self-Assessment Checklist and technical assistance as needed.

SBHC Application Packet is submitted by the SBHC and Sponsoring Entity to DOH/OSAH electronic mail. The Application Packet consists of the following:

- A hard or electronic copy of an acknowledgement of receipt and attestation of adherence to Standards and Benchmarks, signed by the CEO of the sponsoring entity and the SBHC administrator; and a completed SBHC Site Review Self-Assessment, signed by the CEO of the sponsoring entity and the SBHC administrator;
- Hard or electronic copies of:
 - The latest fire inspection report by the fire authority having jurisdiction over the site;
 - Health certificates of all staff;
 - Current license, registration or certificate of each staff member for which a license, registration, or certification is required by the State of New Mexico;
 - Valid drug permit from the New Mexico Board of Pharmacy;
 - Current Clinical Laboratory Improvement Amendments certificate; and
 - Evidence of other licensure and/or certification by appropriate jurisdictional agencies as requested.
- Hard or electronic copies of each of the following:
 - The SBHC's Policy and Procedure Manual, which shall include at a minimum the policies and procedures described in the Standards and Benchmarks;
 - Staff training logs, complaint logs, facility licenses, Material Safety Data Sheets (MSDS), pharmacy logs, laboratory logs, and other materials that may be specified by the Site Review Team; and



Section 14: School-Based Health Centers

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

- Photographs or videos to provide evidence of compliance with such standards as the requirement for “No Smoking” signs, “Handicap Accessibility” signs, and the posting of appropriate licenses.
- Application Packet Review:
 - Reviews of the SBHC’s submissions are completed within 10 business days after the deadline for receipt;
 - DOH/OSAH will review the contents and request further clarification, if needed; and
 - DOH/OSAH will confirm SBHC readiness for review and communicate readiness to HSD/MAD.
- Centennial Care Enrollment:
 - SBHCs must submit to CMS for individual NPI and a MAD 335 application to Conduent as either provider type 313 or provider type 321:
 - SBHCs with Provider Type 313 must present a copy of documentation from CMS certifying the center as an FQHC; and
 - SBHCs with Provider Type 321 must present a copy of the MAD Medicaid Eligibility Letter.
 - Upon completion of the initial Certification, SBHCs will finalize agreements with MCOs and HSD fiscal agent for Fee for Service billing:
 - SBHCs with Provider Type 321 will submit the HSD/MAD letter of New Mexico Medicaid Eligibility as evidence of certification to Conduent; and
 - SBHCs that are already established in Centennial Care will provide evidence of provider type 313 or provider type 321.
 - SBHC will also affiliate with MCO(s):
 - It is the SBHC’s responsibility to contact each MCO; and
 - MCOs are required to make best efforts to contract with SBHCs per Section subsection 4.8.13.1 of the Agreement.



Section 14: School-Based Health Centers

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

- SBHC will also affiliate every rendering provider with SBHC in New Mexico Medicaid System.
- On-Site Review:
 - DOH/OSAH will conduct a telephone or video interview with the SBHC staff and sponsor to discuss findings, questions, concerns, and recommendations;
 - HSD/MAD will issue a letter to the SBHCs, sponsor, DOH/OSAH, and the MCOs within 10 to 15 business days after completion of site review indicating whether the SBHC has passed or failed the review:
 - If the SBHC/Sponsor passed, the HSD/MAD letter will include the effective date the SBHC and Sponsor are eligible to begin billing Medicaid; and
 - If the SBHC/Sponsor failed, the HSD/MAD letter will include the reasons and requirements the SBHC must complete to pass the certification/recertification process. If the SBHC/Sponsor is not able to correct the noted deficiencies within 10 business days from receipt of letter, HSD/MAD will send notification to the SBHC/Sponsor requesting a CAP.
 - The CAP must address each noted deficiency, action steps required to correct the deficiency, and the desired outcome with a due date;
 - The SBHC/Sponsor will have 60 calendar days upon receipt of the notification to implement the CAP and correct all deficiencies. Evidence of the corrections must be submitted to HSD/MAD before or on the 60th calendar day;
 - HSD/MAD will determine what documentation and in what format is required based on the CAP and resolution of deficiencies;
 - HSD/MAD will send a letter of certification/recertification to the SBHC, sponsor, DOH/OSAH, and the MCOs within five business days of resolution of deficiencies and completion of the CAP; and
 - If the CAP is not completed and deficiencies are not resolved, HSD/MAD will collaborate with DOH/OSAH to determine if certification/recertification is possible and next steps.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 14: School-Based Health Centers</p>	<p>Revision dates: August 15, 2014; March 3, 2015, January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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14.3. Recertification Process

The HSD/MAD letter of New Mexico Medicaid Eligibility is issued for a period of three years and is subject to revocation in the event that HSD/MAD becomes aware of loss of appropriate licensure(s) or significant deviation from the Standards and Benchmarks. Recertification must be conducted prior to the expiration of the initial certification and every three years after.

- In January of each year, no later than the first quarterly meeting of the MCO SBHC Advisory Committee, HSD/MAD will provide the MCOs with a list of medically-sponsored DOH/OSAH contracted SBHCs with expiring certifications, including recertification due dates, and the MCO responsible for performing the site review.
- Provider Type 321s with Non-Medical Sponsorship Recertification Process review will be conducted by the HSD/MAD Site Review Team no later than six weeks before the expiration of current certification.
 - DOH/OSAH will schedule the site review through the SBHC’s Sponsoring Entity.
 - DOH/OSAH shall ensure the Sponsoring Entity has access to the most recent copy of the Standards and Benchmarks, SBHC Site Review Self-Assessment, and the Site Review Guide within one month of the site review.
 - The site review will be conducted as outlined in Certification Process above.
- The recertification process for SBHCs sponsored by FQHCs and contracted with DOH/OSAH includes the MCOs. The designated MCO will conduct the site review no later than six weeks before the expiration of current certification.
 - The MCO will schedule the site review with the Medical Sponsor. The review may be conducted remotely. There is no requirement for a site visit.
 - The MCO shall ensure the Medical Sponsor has access to the most recent copy of the Standards and Benchmarks, SBHC Site Review Self-Assessment, and the Site Review Guide within one month of the site review. The designated MCO shall instruct the Medical Sponsor and SBHC to make available hard or electronic copies of:
 - SBHC Policy and Procedure Manual, including the policies and procedures described in the Standards and Benchmarks and the SBHC Site Review Self-Assessment;

	Section 14: School-Based Health Centers	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
---	--	---

- Staff training logs, complaint logs, personnel files, facility licenses, MSDS, pharmacy logs, laboratory logs, and requested medical records;
 - Copies of licensure by jurisdictional agencies including The New Mexico Board of Pharmacy;
 - Any other documentation as deemed necessary after consult with HSD/MAD; and
 - The completed SBHC Site Review Self-Assessment.
- The SBHC may use photographs or audiovisuals to provide evidence that the clinics have required items such as “No Smoking” signs, “Handicap Accessibility” signs, or possession of appropriate licenses.
 - The designated MCO review team shall:
 - Meet with the clinic staff and sponsor representatives in person, by phone or by video conference to discuss the site review process;
 - Review the completed SBHC Site Review Self-Assessment;
 - Use the HSD/MAD electronic Assessment Tool to determine adherence to the SBHC Standards and Benchmarks; and
 - Conduct an exit interview with the staff and sponsor to discuss findings, questions, concerns, and recommendations. A verbal indication will be given of the certification status.
 - The MCO will deliver the site review documentation to HSD/MAD within 10 business days. HSD/MAD will compile the data and make the final determination for recertification.

Confidential Services and Suppression of Explanation of Benefits (EOBs) for SBHC services under New Mexico law. There are a number of circumstances in which an adolescent (an un-emancipated minor) may consent to receive services without parental consent, including the following:

- 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

	Section 14: School-Based Health Centers	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
---	--	---

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 AR, guardian or legal custodian.”

- **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.

- **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.

- **BH 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.”

The HSD and the MCO contracts require the MCOs to adopt and implement written confidentiality policies and procedures that conform to state and Federal laws and regulations. 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 they are required to ensure adult members’ privacy rights under HIPAA and other State and Federal confidentiality provisions.

SBHCs should not bill private payers for services rendered to an adolescent who, according to state law, consented to receive them without parental knowledge.

The MCOs are to suspend the distribution of EOBs for all confidential services provided at SBHCs.

	Section 15: I/T/U	Revision dates: August 15, 2014; March 3, 2015 Effective dates: January 1, 2014
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15. Indian Health Services, Tribal Health Providers, and Urban Indian Providers (I/T/U)


15.1. FQHC/Tribal 638 Claims Processing (Alamo and Pine Hill)

MCOs must configure their systems to pay claims either off of the COBA (Coordination of Benefits Agreement) file or paper claims and pay up to the Medicare OMB rate for the applicable year.

For IHS and Tribal 638 facilities when there is a Medicare reimbursement for services that are not included in the OMB rate, for services billed on a 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 Indian Health Services and Tribal 638 facilities for the full co-insurance and deductible calculated by Medicare regardless of the service or revenue code used.

For services provided to recipients with primary medical coverage by a third party, such as an insurer or other third party (excluding Medicare) who may be liable for the medical bill, Medicaid reimbursed the provider the Medicaid Inpatient or Outpatient OMB rate for that calendar year less the third-party payment.

Services must be delivered in locations identified in Medicaid policy or locations consistent with professional standards of practice. Services locations outside the IHS or Tribal 638 facilities may include locations such as NFs, schools, teen and wellness centers, chapter houses, homes, and non-IHS/Tribal 638 hospitals.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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16. Fair Hearings

16.1. Administrative Hearings

Reference: 8.308.15 NMAC Grievances and Appeals

Under managed care rules, the 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 LOC, or the discontinuation or reduction of an existing service or LOC. However, the right to an appeal and hearing process is also required when a new decision is made, even if that action is to increase or extend a benefit and, therefore, may not initially appear to be “adverse.”

The member may still appeal an action that has been taken to increase or extend the same benefit. For example, if the member receives increase PCO hours, but the hours are less than what the provider requested or less than what the member feels are needed, the member can still appeal that action; and, in the sense that the member is still not satisfied with the number of hours, the action is considered an adverse action, if that is how the member perceives it. When the notice is sent, it should be labeled as the Notice of Action.

Any instance for which an approval, authorization, LOC, frequency, or other amount is not approved to the extent requested by the provider or member is considered an adverse action and may be referred to as such.

Time limits requiring advance notice prior to the MCO taking an adverse action against a member’s existing service or LOC, (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.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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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. The MCO must always make it clear to the member when to file an appeal rather than to file a grievance. A member may file an appeal if he or she is unsatisfied with the outcome of the grievance process as long as the member is still within the time requirement for filing an appeal. However, the appeal is made on the basis of the Notice of Action and not an appeal on the grievance resolution. 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 the 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. The MCO must follow all the requirements of the rule related to the MCO appeal process.

In order to consolidate the requirements of state and Federal rules, MAD has developed checklists for notices and letters contained in the Appendix.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

16.2. The Member’s HSD Administrative Hearing

Reference: 8.352.2 NMAC Claimant Hearings

When the member has exhausted his or her MCO appeal process, and if the member acts within the time frame specified in 8.308.15 NMAC and 8.352.2 NMAC, the member has the right to file a request for an HSD administrative hearing with the FHB. Within HSD, the terms Administrative Hearing and Fair Hearing mean the same thing.

Once a member receives an MCO appeal final decision and the member elects to request an HSD administrative hearing, the member and MCO are governed by the NMAC 8.352.2 rule. The process the member and MCO are to follow for an HSD administrative hearing is detailed in this rule.

Once a member’s request for an HSD administrative hearing has been received by the 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 an HSD administrative hearing final decision is rendered or the member requests the termination of continuation of the benefit.

Once a member notifies the FHB, the FHB acknowledges receipt of the request to the member and notifies the MAD Administrative Hearing Unit (AHU) and the MCO in writing of the request within 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 ARs. 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 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 see redress after his or



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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.

SOE

The MCO must provide MAD with a SOE within 7 calendar days after receipt of a request, but no later than 15 business days prior to the initial scheduled hearing. The SOE must contain copies of all documentation used to make the decision, and it must explain the reasons for the benefit determination and address all of the member's concerns.

Within the specified time frames, the MCO must submit an electronic copy of the SOE to the MAD AHU through the DMZ. The SOE must include relevant NMAC rules, demographic information, summary of issues, clinical and administrative documentation, correspondence, etc. MAD will be responsible for completing the member demographic section of the summary.

The SOE must refer to all relevant State and Federal statutes, rules, and other criteria used to make the decision. Upon request and no later than 7 calendar days after receiving the request, the MCO must provide the member and/or the member's representative (with written consent of the member) the member's case file and provide copies of documents contained therein without charge.

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 the member requested an HSD administrative hearing. The member and other parties to the hearing are provided with the HSD administrative hearing final decision.



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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 the HSD's primary goals related to its administrative hearings is to have all MCO's implement procedures that are consistent with NMAC and 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;
- 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 all MCOs use a standardized HSD SOE form. Each SOE shall contain four 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 Federal 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.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

Each MCO is responsible for its own process while still following the instructions for continuation of benefits for the initial 30 calendar days after transfer; the member’s right to request a MCO appeal, and for a continuation of his or her benefits.

Questions and Answers

- If a member requests an MCO appeal or an HSD administrative hearing for a service that has not been provided, and it is found 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?
 - 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.
 - 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 the 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



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

“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.
- What happens in the case when the receiving MCO does not agree with the relinquishing MCO’s decision?
 - If the relinquishing MCO makes a decision for a benefit for a time period 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



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

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.

- HSD want to emphasize 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, statutes, 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.
- 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?
 - See the answer above. Each MCO handles the issue separately.
- Will the member need to know this is going on and who would be responsible to let the member know this is occurring?
 - The member does need to be informed. The member is entitled to a notice of adverse action from the receiving MCO, as 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.
- Is the current MCO's decision binding regardless of the other MCO's opinion?
 - 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 or administrative hearing process, 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.
- Will each receiving and relinquishing MCO need to continue to do this process anytime a member changes MCO?

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

- Yes, when a member is transitioning to another MCO, and the receiving MCO is intending to take an adverse action effecting a benefit against a member (that is, discontinue or reduce the existing service). 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.
- How will each MCO's Appeal Unit be notified when a member has changed MCO?
 - The relinquishing MCO would know when the member leaves. Its appeal unit should review the enrollment status of the members that have an ongoing 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.

Information to Consider Regarding Member Notices and Letters

All MCOs are required to produce a simple, clear notice or letter that includes the mandated information detailed in the checklists accompanying this Manual section.

It is the MCO's choice on how to address this issue. Some MCOs have been handling this requirement by creating multiple distinct letters and notices that include necessary topics but exclude any irrelevant information. For example, if the issue is the denial of an authorization for a new service, it is not necessary to include "Continuation of Benefits" information in the letter or in the accompanying packet.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

If the adverse action is a benefit that is not currently being provided, there is no need to include information about Continuation of Benefits in the letter or packet. If the Standard Appeal was made in writing, there is no need to include information to the member that if the appeal was made verbally, a written request must be made within 13 calendar days.

Each checklist allows for some variations in the letters and notices that the MCO must have, but the MCO is not limited to the variations specified in the checklists. The MCO may have as many letters and notices as necessary to clearly and effectively communicate to its members.

There must be recognition and use of the standard terms: “Grievance”, “Appeal”, and “HSD Administrative Hearing”. The MCO may use the term “Formal Complaint” instead of “Grievance”; however, the letter should clarify that a Formal Complaint is equivalent to the Grievance process, so a member can relate the terms in the MCO’s notice to the terms used in HSD rules. Notices, letters, forms, and information on the member’s rights should always be clearly labeled.

A Notice of Action is required when a new decision is made, even if the action is to increase or extend a benefit. Therefore, MAD uses the term “Notice of Action”, not “Notice of Adverse Action”.

It is important the Notice of Action be clear in distinguishing between what was requested and what was approved. If everything that was requested is approved, the Notice of Action should state that fact. In such instances, it would be inappropriate to refer to the action as an adverse benefit determination or an adverse action.

When the checklist instructs the MCO to provide a “contact” for the member, it does not have to be the name of a specific individual. The MCO may follow its own process for setting up a contact system.

MCO notices should indicate that a member may request a “quick decision” when the member believes their health or life is endangered while awaiting a decision. This is an important provision so a member whose condition has changed or who need immediate attention can be assisted by the MCO.

Additional Aspects of Approvals and Denials Leading to Appeals

It is important the Notice of Action be based on the most complete information available. Therefore, when considering a LOC or approval of a new item or service, an MCO may ask for

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

additional or clarifying information from the provider requesting the LOC or service in order to arrive at the most appropriate decision and avoid an unnecessary appeal.

An MCO is not required to hold any kind of conference or pre-appeal decision discussion with the requesting provider or the member; however, if the MCO believes this may help resolve the issue, the MCO may schedule such conferences. Failure on the member’s part to attend such a conference cannot be used as a reason to dismiss the appeal.

Before an appeal turns into an HSD Administrative Hearing, it is important it be clear what is in dispute regarding the benefit.


If the Notice of Action is related to a PASRR determination, the member should not be asked to file an appeal with the MCO. Instead, the member should file for an Administrative Hearing; the proper agencies will then become involved in the consideration. If the benefit is already being used, the Continuation of Benefits is automatic and the member never pays for using the continued benefit.

Important Timelines

- **Response to Request for Authorized Service or Other Approval**

A decision on a standard authorization request must be issued as expeditiously as the member’s health condition requires, but no later than 14 calendar days following receipt of the request for new services, and no later than 10 calendar days following receipt of a request to continue ongoing services.

Note that the checklist contains information about a “quick decision” even though that term is not found in rules or contracts. It is important that an MCO be able to assist any member who believes that their health or life is endangered while awaiting a decision; therefore, a member is allowed to change a request for a Standard authorization request to an Expedited authorization request at any time during the appeal process. The member is also able to contact the MCO and express the need for a “quick decision” so that the MCO is informed of any developing medical issues or conditions and can react, as necessary, to that situation. An extension of up to 14 calendar days is allowed when following the HSD MCO contract provisions.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

- **Notice of Action Letter**

A Notice of Action of reduction, increase, or termination of any benefit or LOC or budget amount must be sent to the member at least 10 calendar days prior to the date the intended action will take effect. The same timeframe and requirement for a Notice of Action is necessary following a review or re-determination; when a benefit is extended with no change from the current benefit; or, if a new benefit is approved as requested.

Special provisions apply for members in NFs. Federal regulations in 42 CFR 483.15 require NFs provide a 30-day notice to the member in many instances related to a transfer or discharge. There are exceptions provided. The MCO must be certain the NF has followed Federal requirements and cannot provide a date for the discharge or transfer of a member in an NF that is earlier than the date the NF states in their notice to the member. The MCO Notice of Action does not replace the need for the NF to comply with the Federal requirement. See: Notice Of Action letter to member regarding VAS.

- **Continuation of Benefits may be established using the following process**

The member may request a continuation of a current benefit any time prior to the date the adverse action goes into effect; or within 10 calendar days of the Notice of Action, whichever is later.

- **Appeals**

The member has 60 calendar days from the date of the Notice of Action to file an appeal. If the member appeal is a Standard Appeal and the request is made verbally, the member must submit the appeal in writing within 13 calendar days of the verbal appeal.

If the member appeal is an Expedited Appeal, a verbal request is sufficient; it does not need to be followed up in writing.

MCO Acknowledgement of Member Appeals

The MCO acknowledges the Standard Appeal within 5 business days of the receipt of the appeal. It is important that a MCO be able to assist any member who believes that their health or life is endangered while awaiting a decision: therefore, a member is allowed to change a request for a Standard Appeal to a request for an Expedited Appeal.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

MCO Member Appeal Final Decision Letter

The MCO provides an appeal decision letter within 30 calendar days of the receipt of the appeal for a Standard Appeal, or within 72 hours for an Expedited Appeal; unless a notice of the need for an extension is sent within these same time frames.

The MCO must provide notice to the member within 2 calendar days of any decision to extend the timeframe necessary to provide a decision. See Letter Informing the Member of a Delay for an Appeal Decision.

- **Grievance**

A Grievance may be filed at any time. An MCO cannot change a requested Appeal into a Grievance without written consent from the member.

Acknowledgement of Receipt of a Member-Filed Grievance

An Acknowledgement of a member grievance must be sent within 5 calendar days of receipt by the MCO.

Member Grievance Final Letter

A Resolution of Grievance Letter must be provided within 30 calendar days of the date of receipt of the grievance or as expeditiously as the member’s health require.

Member Grievance Extension Request

The MCO may request an extension from HSD. For any extension not requested by the member, the member must be provided a written notice within 2 calendar days of the decision to extend the time frame.

- **HSD Administrative Hearing**

The member may request an HSD administrative hearing within 90 calendars days of the MCO appeal final decision letter. For an Expedited Hearing, the request must be within 30 calendar days.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	----------------------------------	--

16.3. Appendices

The following pages contain checklists for specific information that must be contained in the Notice of Action to a member, and the other letters and notices associated with steps relating to grievances, appeals, and a final decision letter.

The MCOs are to review their notices and letters, revise them as necessary, and submit them to MAD for final approval.

16.3.1 MCO Checklist – Acknowledgement of Receipt of a Member-filed Grievance

16.3.2 MCO Checklist for Member Grievance Final Letter

16.3.3 MCO Checklist for Notice of Action Letter to Member

16.3.4 MCO Checklist for Notice of Action Letter to Member Regarding Value-Added Services

16.3.5 MCO Checklist for the Acknowledgements of Member Appeals

16.3.6 MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

16.3.7 MCO Checklist for the MCO Member Appeal Final Decision Letter

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
--	---	--

16.3.1. MCO Checklist – Acknowledgement of Receipt of a Member-Filed Grievance


MCO Checklist - Acknowledgement of Receipt of a Member-filed Grievance

The Acknowledgement must include:

- The date that the Grievance was received.
- The MCO's understanding of the issue.
- When the member may expect a resolution or other response to the Grievance, not to exceed 30 calendar days from the receipt of the Grievance.
- That the member has the right to present evidence and testimony and make legal and factual arguments on the issue before the MCO determines the resolution of the Grievance. This presentation may be made by the member, a spokesperson or any designated or authorized representative. The member or authorized individual must make a request for this presentation and the MCO must schedule this presentation prior to making a determination on the Grievance. The MCO must tell the member of the limited time the member has to make this request in order for the MCO to provide a resolution within the required timeframe.

If the Grievance is related to a response to a Notice of Action for which there could be a member Appeal, include the following:

- Information on the difference between a member Grievance and an Appeal, including if they want to file an Appeal they must do so within 60 calendar days of the Notice of Action; and that a Grievance is not considered an Appeal and does not extend the timeframe in which an Appeal must be filed.
- A member may file a Grievance to express dissatisfaction about any matter or aspect of his or her MCO's operation. A member files an Appeal to begin a process for reconsidering an adverse action as described in a Notice of Action.
- Instructions on how to file an MCO member Appeal if the issue is better resolved through an MCO member Appeal instead of an MCO Grievance.
- A statement the member cannot request an MCO member Appeal on the issue if he or she does not agree with the final Grievance decision, unless the timeframe for an Appeal

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	----------------------------------	--

following a Notice of Action is met and the Appeal is based on the Notice of Action, not on the Grievance decision.

- A MCO Grievance contact that includes email and mail addresses, fax and telephone numbers. Include the hours this contact is available, as well as an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter ability.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	----------------------------------	--

16.3.2. MCO Checklist for Member Grievance Final Letter

MCO Checklist for Member Grievance Final Letter

The letter should include the following:

- The date of the letter, which should be the date the letter will be mailed.
- A summary of the Grievance.
- If an action was taken or is going to be taken, include a description of the action.

OR

- An explanation of why no action will be taken to resolve the issue or why no action is necessary. This explanation must be based on rules and requirements or established MCO policies and procedures.
- A statement that the MCO grievance decision letter ends the MCO member Grievance process.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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16.3.3. MCO Checklist for Notice of Action Letter to Member

MCO Checklist for Notice of Action Letter to Member

The following sections, at a minimum, should be included in the written Notice of Action Letter.

There may be two versions as necessary:

1. Notice regarding an existing benefit;
2. Notice regarding a newly requested benefit;
 - Notice of Action letter;
 - Notice of the Right to file a Grievance;
 - Notice of the Right to request an Appeal
 - Notice of the Right to file a Grievance and request an MCO Appeal concurrently; and/or
 - Notice of the Right to a Continuation of Benefits.

Notice of Action should include:

- The date of the Notice, which must be the date the Notice will be mailed. If the Notice is to terminate an existing benefit, the date must not be less than 10 calendar days prior to the date the benefit will end.
- A description of what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current benefit, allocation or budget, including a reduction in LOC, or transfer or discharge of a member residing in a residential facility. If applicable, cite NMAC rules or other criteria that support the basis of the decision. Include the date the benefit will stop or otherwise change. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.

OR

- If the action is a denial, in whole or in part, of a new benefit or service for the member, describe what was requested and what has been denied or otherwise limited. If applicable, cite NMAC rules or other criteria that support the basis of the decision.



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- An MCO contact, including email and mail addresses, fax and telephone numbers. Include the hours this contact is available, as well as an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.

Notice of the right to file an Appeal should include:

- If the member disagrees with the Action, he or she has the right to appeal the decision to the MCO.
- If the member would like to Appeal the decision, the Appeal must be requested within 60 calendar days of the date of the Notice of Action. Include information that if the member misses the deadline, they may lose their right to appeal. Offer to assist the member in requesting or filing for an Appeal and tell them how he or she can obtain that assistance.
- Describe the Standard Appeal process, including the request may be made by phone, but a written request will need to be completed within 13 calendar days of the verbal request.
- Describe the Expedited Appeal process, and that such a request may be made by phone.
- Describe the criterion that merits an Expedited Appeal.
- Inform the member of his or her right to a timely Appeal decision (not longer than 30 calendar days from the request for a Standard Appeal or 72 hours for a MCO Expedited Appeal) and the anticipated date of the Final Appeal Decision.
- Provide appropriate forms for an Appeal that has the member identify how he or she would like to be contacted.

Briefly describe the Appeal process:

- Tell the member that he or she may file a Grievance even if he or she does not request an Appeal. Clarify that the Grievance does not act as Appeal of any adverse action. Tell the member how to file a Grievance.
- Tell the member that he or she may file a Grievance and request an Appeal concurrently.
- Provide a MCO Appeal contact which includes email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number.



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter ability.
- Tell the member that if he or she requests an Appeal, he or she can obtain assistance from an authorized representative, authorized provider, designated spokesperson, or legal counsel. Provide the appropriate form and describe the process to the member.

Tell the member when the he or she requests an Appeal:

- He or she the right to designate an authorized representative. The authorized representative can have access to the case information and may make medical decisions on behalf of the member.
- He or she has the right to designate an authorized provider who agrees to assist him or her. The authorized provider can have access to the case information, but does not have the authority to make medical decisions on behalf of the member.
- He or she has the right to designate a spokesperson. The spokesperson may have access to case information and may speak for the member, but does not have the authority to make medical decisions on behalf of the member.
- He or she has the right to present evidence and testimony and make legal and factual arguments on the issue before the MCO makes a final determination on the Appeal. This presentation may be made by the member, a spokesperson or any designated or authorized representative. The member or authorized must make a request for this presentation and that the MCO will schedule this presentation prior to making a final decision on the appeal. The MCO must tell the member of the limited time the member has to make this request in order that the MCO can provide the decision within the required time frame; and of the member's option to extend the time frame for up to an additional 14 calendar days.
- Neither an MCO or HSD can be held responsible for any fees or costs incurred by the member during the MCO Expedited or Standard Appeal process.

Notice of the Right to Continuation of Benefits when there is an Adverse Action:

If the Action is to terminate, suspend, or reduce the current benefit, allocation or budget, including a reduction in LOC, or transfer or discharge of a member residing in an NF, the letter must include a notice of the right to a continuation of benefits:



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- If the benefit is already being provided, inform the member that he or she can request a continuation of benefits at any time prior to the date the benefit will be terminated based on the Notice of Action. (Note that if the Appeal is initiated by the MCO, the continuation of benefits is automatic and the member never pays for using the continued benefit.)
- Inform the member if he or she requests a continuation of benefits, the member will continue to receive his or her disputed current benefit during the Appeal process, but the member may choose to end his or her continued disputed benefit at any time during the MCO Appeal process or HSD Administrative Hearing.
- Explain the process to request a continuation of his or her disputed current benefit including time frames.
- Provide a phone number to verbally request a continuation of the disputed current benefit and a mailing or email address, or fax number to submit a written request for a continuation of the disputed current benefit.

Provide the MCO member with contact information, the type of disputed current benefit, the number of times a day, week or month the member receives the disputed current benefit, the length of time the benefit is delivered, the LOC of the benefit, or the allocation or budget amount received.

- Include information on the recoupment of the cost of the member's continued disputed current benefit if the MCO's final decision upholds, in whole or in part, its adverse action; and state that if the member later requests an HSD Administrative Hearing in which the final decision upholds the adverse action, in whole or in part, the member will be financially responsible for paying for the services they used.

When the MCO is initiating an MCO Expedited Member Appeal on behalf of the member, in addition to all other requirements, the MCO must:

- Inform the member of the process of an MCO-initiated Expedited Member Appeal.
- Inform the member that the MCO is continuing the member's disputed current benefit throughout the MCO-initiated Expedited Appeal process and that the member is not obligated to repay the continued disputed current benefit if the MCO Member Appeal Final Decision upholds the action.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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16.3.4. MCO Checklist for Notice of Action Letter to Member Regarding VAS

MCO Checklist for Notice of Action Letter to Member Regarding Value-Added Services


Notice of Action should include:

- The date of the Notice, which should be consistent with the date the Notice will be mailed. If the Notice is to terminate an existing benefit, the date must be no less than 10 calendar days prior to the date the benefit will end.

Describe what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current value-added benefit. If applicable, cite NMAC rules or other criteria which may support the basis of the decision. Include the date the benefit will stop or otherwise change. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.

OR

- If the action is the denial, in whole or in part, of a new benefit or service for the member, describe what was requested and what has been denied or otherwise limited. If applicable, cite NMAC rules or other criteria which may support the basis of the decision.
- Include a statement that an MCO VAS adverse determination cannot be appealed through the MCO or reviewed through an HSD Administrative Hearing.
- If applicable, describe alternative MAD benefits that the member may utilize to replace the terminated VAS.
- Provide MCO contact, including email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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16.3.5. MCO Checklist for the Acknowledgements of Member Appeals

MCO Checklist for the Acknowledgements of Member Appeals

The MCO should have, at a minimum, six separate but similar letters:

- Acknowledgement of a written Standard Appeal;
- Acknowledgement of a verbal Standard Appeal;
- Acknowledgement of a Standard Appeal, but the MCO or member changes it to an Expedited Appeal;
- Acknowledgement of an Expedited Appeal;
- Acknowledgement of an Expedited Appeal but Denying the Expedited Status; and/or
- Notice of a MCO initiated Expedited Appeal and Continuation of Benefits.

Requirements

An Appeal request must always be followed by an acknowledgement within 5 business days of receipt of an Appeal. Copies of the acknowledgement and any associated documents must be sent to the member, any authorized representative, and to the provider who requested the disputed benefit.

- If the acknowledgement letter is in response to a verbal request for a Standard Appeal, the acknowledgement must: contain information about the 13 calendar day requirement to submit a written Appeal, include the fact that if the member misses that deadline, they may lose their right to an Appeal, and an offer to assist the member with the written Appeal.
- The MCO must provide the Appeal form and offer to assist the member if they need help completing it. (A request in writing from the member is not required for an Expedited Appeal.)

The Appeal acknowledgement must include the following:

- The date of the acknowledgement, which should be consistent with the date the acknowledgement letter will be mailed.



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- The date the Expedited or Standard Appeal request was received by the MCO and a brief statement of the MCO's understanding of the issue the member is appealing.
- The anticipated date of the Appeal decision, which may be in the form of "no later than."
- The date of any scheduled informal conference to help clarify or settle the issue. Inform the member they must adhere to the date or contact the MCO to change the date, if necessary. The scheduling of an informal conference is not mandatory, but may be requested by the MCO.
- A MCO Appeal contact which includes email and mail addresses, fax and phone numbers. Include the hours that these contacts are available, as well as any other emergency number that may be available. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.
- Inform the member of his or her right to have someone with them or to represent them in their Appeal and that if they would like someone to represent them, they must make a request in writing. Provide the appropriate form and describe the process to the member.
- Inform the member of how to submit additional information regarding the issue, if the member or provider has more information to provide.
- Inform the member of his or her right to a continuation of benefits if the benefit is already being provided and the member has not already requested a continuation of the disputed current benefit. (This information should have also been previously provided in the Notice of Action.) Inform the member that he or she can request a continuation of benefits at any time prior to the date the benefit will be terminated, based on the Notice of Action, or within 10 calendar days of the date of the notice, whichever is the longer period of time. (Note that if the Appeal is initiated by the MCO, the continuation of benefits is automatic and the member never pays for using the continued benefit.)
- Inform the member if he or she requests a continuation of benefits, the member will continue to receive his or her disputed current benefit during the Appeal process. Include information on the recoupment of the cost of the member's continued disputed current benefit if the MCO's final decision upholds, in whole or in part, its adverse action; and state that if the member later requests an HSD Administrative Hearing if the final decision upholds the



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

adverse action, the member will be financially responsible for paying for the services they used.

- Provide the member with contact information for requesting a continuation of benefits.
- Inform the member that he or she may choose to end his or her continued disputed benefit at any time during the MCO Appeal process or HSD Administrative Hearing process.

Include a statement of the member's rights that includes the following:

- The member's right to a timely decision on the Appeal; a decision must be provided within 30 calendar days from the request for a Standard Appeal or 72 hours from the request for an Expedited Appeal, unless notice is provided by the member or the MCO that additional time is required.
- That either the member or the MCO have the right to extend the time frame up to 14 calendar days if necessary, but if the MCO extends the time frame, the member has the right to file a Grievance with the MCO, if he or she disagrees with the extension.
- That if the member believes that their health or life is endangered while awaiting a decision, the member at any time during the appeal process can ask for a "quick" decision by requesting the Appeal be changed to an Expedited Appeal, in which a decision is usually made within 72 hours; or if it is an emergency, the decision will be made as soon as possible.

Outline the process that can occur if the Appeal decision is not in the member's favor:

- State that after the MCO Appeals process, if the member would like to continue the Appeal, he or she may do so by requesting:
 - An HSD Expedited Administrative Hearing within 30 calendar days of the date of the MCO Member Appeal Final Decision;
 - An HSD Standard Administrative Hearing within 90 calendar days of the date of the MCO Member Appeal Final Decision; and/or
 - That more information on requesting an HSD Administrative Hearing will be included in the Appeal Decision Letter if the decision is not in favor of the member.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
--	----------------------------------	--

- Inform the member that he or she may also request for an HSD Administrative Hearing, if the decision on their Appeal is not timely.

- Inform the member that he or she may file a request for an HSD Administrative Hearing if the member requested an Expedited Appeal, but the MCO denies the expedited status. The HSD Administrative Hearing will be limited to the issue of expediting the MCO Appeal decision.

The acknowledgement must be in clear and simple verbiage. If the MCO has a packet of information accompanying the letter, some of the detailed information may be in the packet rather than in the letter, as long as the letter directs the member to look there.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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16.3.6. MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

MCO Checklist for Letter Informing the Member of a Delay for an Appeal Decision

The Letter should include:

- The date of the letter, which should be consistent with the date the letter will be mailed. If the pending Appeal Decision is regarding termination of an existing benefit, the date must not be less than 10 calendar days prior to the date the benefit will end. It is also a requirement to make a reasonable effort to provide the member with information regarding the delay orally, in addition to the written Acknowledgement.
- Describe what action the MCO intends to take or has taken to terminate, suspend, change or reduce the current benefit, or for a new benefit, intends to deny or limit.
- Include the new date the benefit will terminate or otherwise change, if a delay in a decision is going to delay the date of the benefit change or termination. A letter is required even if the change is to increase a benefit or if there has been a new review and the same benefit is extended.
- State the date a decision was due and the length of time the decision will be delayed. Include the date a final decision is expected. Include the justification of why the decision is being delayed.
- Tell the member that if he or she disagrees with the delay, they have the right to file a Grievance. Describe the process on how they do so, including any forms that are necessary.
- Provide an MCO contact, including email and mail addresses, fax and phone numbers. Include the hours that this contact is available, as well as an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.
- Tell the member that if the MCO does not provide a decision within the required 14 calendar day extended time frame, the member has the right to request an HSD Administrative Hearing which will result in the Administrative Hearing process making the final decision on the issue being appealed.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 16: Fair Hearings</p>	<p>Revision dates: August 15, 2014; March 3, 2015; January 1, 2019</p> <p>Effective dates: January 1, 2014</p>
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16.3.7. MCO Checklist for the MCO Member Appeal Final Decision Letter

MCO Checklist for the MCO Member Appeal Final Decision Letter

The MCO should have, at a minimum, three separate but similar letters:

- Reversal of MCO Adverse Action;
- Partial Reversal of MCO Adverse Action; and
- No Reversal of MCO Adverse Action.

1. Letter for Reversal of MCO Action and Approval of the Benefit. Include in the notice of the reversal of the MCO’s adverse action:

- The date of the letter, which should be consistent with the date the letter will be mailed.
- The date that the disputed benefit will start if the benefit was not continued or supplied during the appeal process.
- A MCO contact in case the member has any questions. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number if one is available. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.

2. Letter for partial reversal of MCO Adverse Action.

Approved Benefit:

- Inform the member of the date the disputed benefit will start if the benefit was not continued or supplied during the appeal process.
- Provide an MCO contact in case the member has any questions. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number if one is available. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.

Denied Benefit:



Section 16: Fair Hearings

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

- Inform the member what disputed benefit was denied. State the date the denied benefit will be terminated if it is currently being supplied.
- Include a statement describing any rationale for the decision to deny the disputed benefit.
- If applicable, cite NMAC rules or other reasoning used to make the final decision.
- If the member had a continuation of benefits, inform the member what the recoupment cost is and how the MCO will start recoupment.
- Provide an MCO contact who can explain the recoupment process and who can assist the member to request an HSD Administrative Hearing if the member chooses to do so. Include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.
- Include Member Rights and Information to Request an HSD Administrative Hearing: Include the same information in that letter as described below, under the “Letter Upholding the Action.”

3. Letter Upholding the Action:

- Include a statement describing the rationale to deny the disputed benefit.
- If applicable; cite NMAC rules or other reasoning used to make the final decision.
- Inform the member of the date the denied benefit will be terminated if it has been continued during the Appeal.
- If the member had a continuation of benefits, inform the member what the recoupment cost is and how the MCO will start recoupment.
- Provide an MCO contact who can explain the recoupment process and who can assist the member to request an HSD Administrative Hearing if the member chooses to do so. The contact information must include email and mail addresses, fax and phone numbers, the hours that the contact is available, and an emergency number. Inform the member to use this contact information if he or she has any questions. Inform the member how to access toll-free numbers with TTY/TTD and interpreter capability.

	Section 16: Fair Hearings	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
---	----------------------------------	--

- Inform the member that he or she may choose to end his or her continued disputed current benefit at any time prior to and during the HSD Administrative Hearing process.
- Inform the member that they may request an HSD Standard Administrative Hearing within 90 calendar days of the date of the MCO Expedited or Standard Member Appeal Final Decision letter.
- Inform the member they may request an HSD Expedited Administrative Hearing within 30 calendar days of the date of the Appeal Final Decision letter. The request for an HSD Expedited Administrative Hearing may be made verbally or in writing.
- Provide the member with the HSD Fair Hearing Bureau email and mail addresses, fax and phone numbers, HSD toll-free numbers with TTY/TTD and interpreter capability.
- Inform the member that if they request an HSD Administrative Hearing, the MCO will not take steps to recoup the cost of the member's current disputed benefit until the HSD Administrative Hearing process is over, unless requested to do so by the member.
- Inform the member he or she may choose to end his or her continued disputed current benefit at any time prior to and during the HSD Administrative Hearing process.
- Inform the member of the recoupment of the cost of the member's continued disputed current benefit if the HSD Administrative Hearing Final Decision letter upholds the MCO's Action.

All letters must be in clear and simple verbiage. If the MCO has a packet of information accompanying the letter, some of the detailed information may be in the packet, as long as the letter directs the member to look there.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17. Managed Care Reporting

17.1. General Information

MCOs are required to comply with all reporting requirements established by HSD as specified in the Agreement, which details requirements for timely submission, formatting, completeness and accuracy of content. MCOs are provided with State-approved instructions and templates to facilitate timely, complete, and accurate reporting. A complete list of current reports is incorporated in this Manual as 17.8.1: Centennial Care MCO Reports.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.2. General Requirements

HSD, at its discretion, may request information and/or data, identified as ad hoc requests. Ad hoc requests are issued to the MCOs for various reasons and information is generally requested to address a separate and distinct issue or to provide clarification on issues that fall outside the scope of reporting (i.e., provider information, claims research, NF census, etc.).

MCOs are required to implement continuous improvement processes to identify instances and patterns of non-compliance. Identified patterns of non-compliance are addressed internally by MCOs to improve overall performance and compliance.

At its discretion, HSD may, at any time, revise existing report content, and HSD may seek MCO input on proposed changes. Once HSD issues finalized Report Instructions and Templates, MCOs will have at least 14 calendar days, and additional time at HSD’s discretion, to implement report content changes depending on the nature of the changes.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.3. MCO Reporting and Intake

HSD's report management process involves the following:

- Downloading MCO report submissions via Xerox secure File Transfer Protocol (FTP) site;
- Processing MCO report submissions, resubmissions and other related documents;
- Acknowledging receipt of reports within 45 calendar days of receipt of the report upload date;
- Performing an initial quality check to ensure the MCO report is timely, accurate, complete, formatted correctly, submitted on the correct template version and is accompanied by a signed and dated Attestation;
- Recording all report review information and actions into a MCO Reports Tracking Tool;
- Assigning MCO reports to Subject Matter Experts (SMEs) who possess the knowledge and experience to conduct a thorough analysis of MCO reports and verify MCO compliance with HSD requirements and performance standards;
- Tracking and monitoring the MCO report review and data analysis process;
- Managing HSD Lead Report Reviewer timeframes; and
- Uploading HSD feedback (Acceptance, Rejection, Final Review Tool, etc.) to the FTP site.


 <p>HUMAN SERVICES DEPARTMENT</p>	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.4. Report Rejection

An MCO Report may be rejected, by HSD, due to the following reason(s):

- Data inaccuracies;
- Signed Attestation not included;
- Incomplete information (e.g., data missing in fields);
- Formatted incorrectly;
- Incorrect template;
- Incorrect naming convention; and/or
- Incorrect reporting period, MCO name and report run date.

The HSD Contract Manager will determine whether a Rejection is warranted, or if a technical assistance call or other solution is preferred.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.5. MCO Report Resubmission

HSD has developed and implemented several processes (technical assistance call, self-identified error resubmission [SIER]) to allow for improvement of the MCOs' data accuracy and reporting compliance.

Technical Assistance Call Process

HSD Contract Managers and SMEs are available to provide technical assistance to MCOs in the following areas:

- Review of HSD feedback of reports;
- Discuss extension requests of report submission deadlines; and
- Press to resolve reporting concerns;

In an effort to maximize and improve MCO reporting and data efficiency levels, HSD may conduct a technical assistance call to address data-related questions and concerns. This provides an opportunity for MCOs to gain valuable guidance from HSD Contract Managers and SMEs.

After a technical assistance Call is held, the HSD Contract Manager determines whether the MCO's report is Accepted or Rejected.

Self-Identified Error Resubmission

In addition to Section 4.21.1.6 of the Agreement, MCOs must upload a SIER report within the deadline specified by an HSD Contract Manager.

MCOs are required to accurately label each subsequent report submission with the appropriate version number (v2, v3, v4).

HSD Contract Managers approve all MCO Report Rejections and SIERS; manage the technical assistance call process; and direct the overall resubmission of MCO reports.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.6. Report Revisions

HSD conducts report revisions as necessary through a formal, written process in which MCOs and end users request needed changes to data reporting metrics. This process is intended to streamline managed care reporting and reduce administrative burden by limiting data collection, where possible, to meet Federal and state requirements. Changes to HSD’s managed care data reporting also support the needs of external agencies and stakeholders.

The report revision process begins with submission of a formal request to HSD. If the request is approved, the Centennial Care Contracts Bureau will organize a revision workgroup with SMEs and report reviewers to make required revisions or modifications.

When the workgroup completes this function, a draft reporting package is submitted to MCOs for comment and testing. Comments may be rejected or accepted, resulting in additional revisions to the reporting package. HSD then issues the final reporting package to MCOs for implementation.

	Section 17: Managed Care Reporting	Revision dates: August 15, 2014; March 3, 2015; January 1, 2019 Effective dates: January 1, 2014
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17.7. 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 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 hours, MCOs are directed to notify HSD immediately via email at HSD.MCOSystemsAvail@state.nm.us. MCOs are to provide HSD within five business days, documentation that includes a CAP describing how MCO will prevent the problem from occurring again.

In the event of any critical systems unavailability that has been approved by HSD but the amount of downtime exceeds what was initially approved by HSD, MCOs must notify HSD immediately via email at 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 John Padilla, MAD, at (505) 827-1340 and email him at JohnH.Padilla@state.nm.us.

For any email notification pertaining to the above direction, MCOs must use the HSD-developed template included in this Section as 17.8.2: Systems Availability Incident or Event Report.



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

17.8. Appendices

17.8.1 Centennial Care MCO Reports

17.8.2 Systems Availability Incident or Event Report



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

17.8.1. Centennial Care MCO Reports

Report No.	Report Title	Frequency	Report Objective	Comment
1	Native American Members Report	Quarterly	To ensure Native American members have access to care and are receiving needed services.	
2	Call Center Report - Monthly	Monthly	To capture call center statistics and ensure that callers can access a call center agent in a timely manner.	
3	Network Adequacy Report	Quarterly	To monitor the MCO's compliance in maintaining an adequate and efficient provider network, tracking new and terminated providers and single-case agreements.	
4	Self-Directed Report	Quarterly	To (i) monitor the amount of the annual SDCB budget used by members, (ii) identify the services that are highly utilized, (iii) identify members that have over-utilized or under-utilized their annual CB budget, and (iv) identify members whose cost of care in the community is greater than 80% of the cost of care in a private NF.	
5	Admissions and Readmissions Report	Quarterly	To monitor the number of members who are readmitted to a facility such as, an RTC, TFC, hospital, within 30 calendar days of a previous discharge and to track follow-up appointments after discharge.	
6	Care Coordination Report	Quarterly	The Care Coordination report monitors assessments, ongoing care coordination activities, and changes of care coordination levels for all levels of care coordination.	On Hold
8	Level of Care (LOC) Report	Monthly	To capture data regarding the nursing facility (NF) LOC determination process including timeframes, activities of daily living, and care settings.	



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Report No.	Report Title	Frequency	Report Objective	Comment
9	Agency-Based Community Benefit (ABCB) Report	Quarterly	To (i) monitor the number of members that changed to ABCB, (ii) identify the services used by members receiving ABCB, and (iii) identify members whose cost of care in the community is greater than 80% of the cost of care in a private NF.	
12	Provider Satisfaction Survey Report	Annually	To review the results from the survey, including information regarding overall satisfaction (claims, provider relations, network, utilization and quality management, pharmacy and drug benefits, and continuity of care).	
15	Audited HEDIS Results	Annually	To monitor and review audited HEDIS results.	
18	UM Program Description, Associated Work Plan and Evaluation	Annually	To monitor the MCO's UM Program Evaluation to monitor overall effectiveness, an overview of UM activities, and an assessment of the impact of the UM program on management and administrative activities. The MCO's review and analysis shall be incorporated in the development of its following year's UM Work Plan.	
19	UM Program Evaluation	Annually	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.	LOD #29: Combined with 18
20	Disease Management Description and Evaluation	Annually	To monitor and review the MCO's Disease Management program which includes a description of MCO activities regarding chronic conditions identified in the Disease Management program description. Disease Management is a component of care coordination and must include BH as part of the program.	
21	Disease Management Annual Evaluation	Annually	To evaluate the MCO's Disease Management program.	LOD #29: – Combined with 20
22	QM/QI Program Description and Associated Work Plan	Annually	To monitor and review the MCO's Annual QM/QI Program Description and Associated Work Plan to include goals, objectives, structure, and policies and procedures that address continuous QI for PH and BH.	



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Report No.	Report Title	Frequency	Report Objective	Comment
23	QM/QI Program Annual Evaluation	Annually	To monitor the MCO's QM/QI Program Evaluation for the previous year's activities.	
25	CAHPS Results Report	Annually	To review and evaluate the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results report.	
27	Activities of the Member Advisory Boards	Semi Annually	To review Member Advisory Board meeting agendas for general MCO membership, Native American representation, BH, and CB subgroups.	LOD #29: Report 27 Combined with 27a and 32; now semi-annually.
27a	Subgroup of the Member Advisory Board (BH, Self-Directed, etc.)	10 business days following each meeting	To Monitor the activities of subgroups of the Member Advisory Board.	LOD #29: Combined with 27 and 32.
31	Health Education Evaluation Report	Annually	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.	LOD #29: Combined with 30.
32	Activities of the Native American Advisory Board Report	10 business days following each meeting	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.	LOD #29: Combined with 27 and 27a.
35	Electronic Visit Verification (EVV)	Quarterly	To review and evaluate the use of EVV systems of the MCOs.	
36	Critical Incidents Report - Quarterly	Quarterly	To monitor key metrics regarding critical incident reporting for specific subpopulations and the MCO's actions in response to critical incidents.	LOD #29: Report Number changed from 36B to 36.
37	Grievances and Appeals Report	Monthly	To monitor member and provider grievances, appeals and fair hearings and to track MCO adherence to contractual timeframes.	



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Report No.	Report Title	Frequency	Report Objective	Comment
38	Provider Training and Outreach Plan and Evaluation Report	Annually	To monitor and review the MCO's plans for provider training and outreach.	
39	Provider Training and Outreach Plan Evaluation Report	Annually	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 (QI) program/QI 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.	LOD #29B: Combined with #38
42	Prior Authorization Report	Quarterly	To capture information on services requiring prior authorization and examine changes and trends in authorizations and denials of services over time.	
44	Pharmacy Report	Monthly	To monitor pharmacy utilization and cost, including dispensing fees, over- and under-utilization of drugs including controlled substances, utilization of formulary drugs, non-formulary drugs, over the counter, generic, and brand drugs.	
45	BH Members Services/CSA Report	Quarterly	To monitor the number and types of members served through CSAs and the types of services provided to such members.	On Hold Pending Revision
47	Claims Activity Report	Quarterly	Claims Activity Section – To capture data related to the disposition of claims, timeliness of claims adjudication, payments on clean claims to providers, interest paid, and claim aging. This section of the report captures claims data separately for PH providers, BH providers, I/T/Us (Indian Health Service, Tribal health providers, and Urban Indian providers), and specialty-pay providers (day activity providers, assisted living providers, nursing facilities, home care agencies, and CB providers). Claims Payment Accuracy Section – To report the findings of the MCO's internal audit of quarterly claim payments and to monitor the accuracy of those claims paid.	LOD #29 C: Frequency of submission changed from Monthly to Quarterly



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Report No.	Report Title	Frequency	Report Objective	Comment
48	Patient Centered Medical Homes (PCMH) Report	Quarterly	To track (i) the number of PCMHs established, (ii) the number of members that were referred to and joined a PCMH, (iii) outcomes, including emergency room utilization and hospital admission and readmission, and (iv) PCMH NCQA recognition and other accreditation.	LOD #29: Frequency of submission changed from Semi-Annually to Quarterly
49	Provider Network Development, Management Plan and Evaluation	Annually	To monitor and review the MCO's plans for developing and managing its provider network to ensure all medically necessary services are accessible and available.	
50	Provider Network Development and Management Evaluation Report	Annually	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.	LOD #29:-- Combined with 49
51	Provider Suspensions and Terminations Report	Semi Annually	To monitor the suspensions and terminations of providers and the number of members impacted.	LOD #29: Frequency of report submission changed from Quarterly to Semi-Annually
53	PCP Report	Quarterly	To capture information regarding PCP member ratios, open panels and assignment/change activity for non-dual members.	LOD #29: Frequency of submission changed from Monthly to Quarterly
55	Geo/Access Report	Quarterly	To monitor access to services by county and across urban, rural, and frontier counties.	
56	Program Integrity Report	Quarterly	To monitor fraud, waste, and abuse cases, preliminary investigations, suspicious activities, adverse actions, and financial program integrity activities of the managed care organization.	
61	Medicaid School-Based Health Centers (SBHC)	Quarterly	To track the quantity and types of services billed by school-based health centers.	On Hold – LOD #29 (pending revision)
63	Developmental Disabilities (DDs) Specialty Dental Report	Quarterly	To monitor dental visits for members with DDs.	



Section 17: Managed Care Reporting

Revision dates: August 15, 2014;
March 3, 2015; January 1, 2019

Effective dates: January 1, 2014

Report No.	Report Title	Frequency	Report Objective	Comment
64	Jackson Class Members Report	Quarterly	To monitor MCO performance in processing requests for and delivering new adaptive equipment and modifications or repairs to adaptive equipment.	
66	Health Homes (HHs) Report	Quarterly	To track (i) the number of HHs established; (ii) the number of members referred to and joined a HH (iii) outcomes, including emergency room utilization and hospital admissions and readmissions.	On Hold – LOD #29 This report is in development

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 18: Quality	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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18. Quality

18.1. Performance Improvement Projects (PIPs)

In addition, to the three PIPs outlined in the Agreement (one related to long-term services, one related to prenatal and postpartum, and one related to adult obesity), the MCO shall be required to do the following two PIPs based on the most current CMS Adult Core Set.

- Diabetes prevention and enhanced disease management:
 - PQI01-AD: Diabetes, Short-Term Complications Admission Rate (NQF #0272); and
 - HA1C-AD: Comprehensive Diabetes Care: Hemoglobin A1c Testing (NQF #0057)
- Screening and management for clinical depression
 - AMM-AD: Antidepressant Medication Management (NQF #0105); and
 - CDF-AD: Screening for Clinical Depression and Follow-Up Plan (NQF #0418)

These PIPs shall follow all CMS EQR protocols and will be reviewed annually by the EQRO based on the most current EQR protocols.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 18: Quality	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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18.2. Provider Satisfaction Survey

The Provider Satisfaction Survey is an annual report that provides the MCO with an assessment of its activities, policies and procedures related to identifying healthcare performance, improvements and internal systems based upon satisfaction of its contracted providers. HSD has outlined specific requirements to be included in the provider satisfaction survey. Those requirements are incorporated into the Provider Satisfaction Survey reporting instructions. The survey requirements list the detailed description of:

- Three populations to target;
- Rating system to follow;
- Topics to address; and
- Template of the required questions, which are attached in 18.4.1.

	Section 18: Quality	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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18.3. Critical Incident Reporting

All agencies in New Mexico providing HCBS and BH services are required to report Critical Incidents within 24 hours of knowledge of the occurrence. The critical incident(s) should be reported to the member’s MCO and/or APS or Child Protective Services (CPS) as necessary.

Critical incident reporting responsibilities and reporting requirements include:

- HCBS critical incidents involving members with a qualifying COE must be reported on the HSD Critical Incident Reporting System for the following reportable incidents: abuse; neglect; exploitation; deaths; environmental hazards; missing/elopement; law enforcement; and emergency services.
 - Qualifying COEs include: 001; 003; 004; 081; 083; 084; 090; 091; 092; 093; 094; 100; and 200 with an NF LOC.
- BH critical incidents and all Sentinel Events are defined by the BH Critical Incident Protocol.
 - Critical incidents involving BH services for members with a non-qualifying COE must be reported on the Centennial Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin or other reportable incidents.
 - The MCO shall have a process and designate one fax line to receive critical incident reports from BH providers for Medicaid recipients. The MCO shall provide this fax number to HSD and the MCO contracted BH provider network.
 - The MCO is responsible for reviewing and ensuring complete follow up has occurred regarding all submitted BH critical incidents reported by or on behalf of their members, including APS and CPS.
 - The MCO will notify BHSD of all Sentinel Events in accordance with the BH Critical Incident Protocol.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 18: Quality	Revision dates: August 15, 2014; March 3, 2015, January 1, 2019 Effective dates: January 1, 2014
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18.4. Appendix

18.4.1 Centennial Care Reporting Survey Template



Section 18: Quality

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

18.4.1. Centennial Care Reporting Survey Template

Centennial Care Reporting Survey Template

MCO survey results shall utilize the following rating system:

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

The survey shall include the following required questions:

Care Coordination/Continuity of Care

Effectiveness of MCOs care coordination/care management programs for members.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Assistance provided by care coordination/care management staff.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

MCO provides information needed to care for its members.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Overall Satisfaction

Likelihood you would recommend the MCO to other members?

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Likelihood you would recommend the MCO to other physicians?

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Overall satisfaction with MCO.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Claims

MCOs accuracy of claims processing.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

MCOs timeliness of claims processing.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1



Section 18: Quality

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

MCOs timeliness of adjustment/appeal claims processing.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Ease of resolving claims issues without making multiple inquiries.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Provider Relations

MCOs process of obtaining member information (eligibility, benefit coverage, co-pay amounts).

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Satisfaction with MCOs customer service in answering questions and/or resolving problems when calling the MCO.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

MCOs frequency and effectiveness of provider representative visits to the provider's office.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Usefulness of MCOs written communications, policy bulletins, and manuals.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Quality of provider orientation and education processes.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Ease of completing MCO credentialing and re-credentialing.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

MCOs attentiveness to the provider's overall needs.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Provider Network

Quality of the MCO's primary care practitioners.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Quality of the MCO's specialists.



Section 18: Quality

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

The number of quality specialists to whom the provider can refer patients.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

The number of specialists in the MCO's provider network.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Utilization/Quality Management

Ease of the prior authorization process.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Timeliness of obtaining outpatient authorization of services.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Timeliness of obtaining inpatient authorization of services.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Satisfaction with coordination of home health and DME services.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Procedures for obtaining pre-certification/referral/authorization information.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Degree to which the plan covers and encourages preventive care and wellness.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Clinical appropriateness of UM decision.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Pharmacy/Drug Benefits

Ease of using formulary.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Ease of the pharmacy prior authorization process.



Section 18: Quality

Revision dates: August 15, 2014;
March 3, 2015, January 1, 2019

Effective dates: January 1, 2014

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

MCOs variety of drugs available in formulary.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Timeliness of response to pharmacy prior authorization requests.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Extent to which formulary reflects current standards of care.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Ease of prescribing preferred medications within formulary guidelines.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

Availability of comparable drugs to substitute those not included in the formulary.

Excellent – 6 Very Good – 5 Good – 4 Fair – 3 Poor – 2 Don't know – 1

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
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19. Program Integrity

19.1. General Information

The Centennial Care MCOs shall comply with all Program Integrity provisions of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) (collectively "PPACA "), and its regulations.

	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
---	--------------------------------------	--

19.2. Fraud, Waste and Abuse Requirements

This section provides further guidance to the Agreement and clarifies the requirements set forth in the following sections of the Agreement: 4.17.1 (Program Integrity - General); 4.17.2 (Program Integrity - Reporting and Investigating Suspected Fraud and Abuse); and 7.27 (Cooperation Regarding Fraud).

Provider profiling, auditing and data mining must occur on a regular basis to assist in the identification of potential fraud, waste and abuse. This includes, but is not limited to, an automated review of claims or a clinical audit. Information may also be used from external sources. When an MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity, it must comply with the following:

Initial Report

- For PH or LTC services, make an initial report within five business days from the time the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity to the New Mexico HSD, OIG’s Program Integrity Unit (PIU). The MCO must identify whether it is an initial report.
- For BH services provided to Medicaid recipients, make an initial report within five business days from the time the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity to PIU and the New Mexico Behavioral Health Collaborative (the "Collaborative"). The MCO must identify whether it is an initial report.
- The MCO must document the identification of potential fraud, or allegation of potential fraud or suspicious activity on the HSD Program Integrity Report ("Report 56") pursuant to the "Centennial Care Reporting Instructions Program Integrity- Report #56".

MCO Investigation

- Once initially reported, the MCO must begin the investigation promptly in order to ensure that is completed within 12 months, including all reports as required by the Agreement or set forth herein (see, information below), from when the MCO identified potential fraud, or became aware of an allegation of potential fraud or suspicious activity, from when it was initially reported to the PIU. The MCO must use the PIU supplied Special Investigative Unit



Section 19: Program Integrity

Revision dates:

Effective date: January 1, 2019

(SIU) Case Summary form when reporting Fraud, Waste and Abuse to the PIU. The SIU Case Summary form may include, but is not limited to, the following information:

- Date of the initial report to PIU;
- With each update to PIU, identify the report as an update and the date of the update;
- Provider(s), member(s), and/or caregiver(s) full name, and any other known names used, that are the subject(s) of the referral;
- Any known relationships between provider(s), member(s), and/or caregiver(s) (i.e., business, personal, etc.);
- If a provider, whether they are a billing or rendering provider, and the name(s), address, telephone number of the reciprocal billing or rendering provider;
- If known, NPI, TIN, SSN, DOB, Medicaid/Medicare Provider Number, Medicare Number, Medicaid Number, address, phone number, and/or product line for the subject(s) of the referral. If not known, identify as "Unk";
- If known, the complainant's contact information to include, name, physical address, email address and phone number. If not known, identify as "Unk";
- MCO's case file number, date the MCO opened the case, allegation description and code number, and source of the complaint, i.e. hotline, letter, email, etc.;
- Verify whether the member, caregiver, or provider has been previously investigated during the previous five years and summarize what was found previously;
- Identify and review claim(s), billing(s), and payment history, and summarize what was found;
- Identify and review internal policies and procedures, and summarize what was found;
- Identify and review provider's credentials and member's eligibility status, and summarize what was found;
- Identify and review state rules, service definitions, and manuals, and summarize what was found;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 19: Program Integrity</p>	<p>Revision dates:</p> <p>Effective date: January 1, 2019</p>
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- Determine if the MCO previously provided education to the provider or member as it relates to the suspicious activities, and summarize what was found;
- Document all investigative findings in the SIU Case Summary form;
- Identify the total potential overpayment resulting from fraud and the time period for the claims reviewed; and
- Identify whether the potential overpayment was recovered in whole or in part, and if in part, the amount recovered and the remaining balance.

The information identified above is fundamental for the PIU to determine a credible allegation of fraud and if the MCO has this information, it should be included in the MCO's SIU Case Summary form to the PIU. The MCO should also identify and summarize those investigative steps taken that have no results and include them in the MCO's SIU Case Summary form to the PIU.

- In conducting their investigation, the MCO should keep in mind the definition of a credible allegation of fraud, 42 CFR 455.2, and the obligations for an investigation set forth in 42 CFR 455.14.
- During the time that the MCO is conducting its investigation, it shall provide the PIU, and when appropriate the Collaborative, with updates as requested.
- Within the 12-month period and within 10 business days of completing their investigation, the MCO shall report the results to the PIU, and when appropriate the Collaborative, using the SIU Case Summary form and state whether the MCO determined:
 - The allegations are unsubstantiated and no further action is recommended;
 - The allegations resulted in a potential overpayment; or
 - The allegations resulted in a referral to the PIU with a recommendation that a credible allegation of fraud may have been identified.

The MCO will use their last significant investigative action resulting in information that is significant and relevant to the investigation as the date their investigation was completed. This may include, but is not limited to, interview, document analysis, document receipt, etc.

- Upon completion of their investigation, the MCO shall update Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity-Report #56".

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 19: Program Integrity</p>	<p>Revision dates:</p> <p>Effective date: January 1, 2019</p>
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Overpayments

- If, as a result of their investigation, the MCO determines that an overpayment exists, the MCO shall report to the PIU, and when appropriate to the Collaborative, using the SIU Case Summary form:
 - The overpayment amount;
 - The claims identified for overpayment recoupment such claims being reflected on the MCO's encounter data;
 - If the overpayment amount is extrapolated, the methodology used for the extrapolation;
 - The date the provider was notified of the overpayment;
 - The terms of any repayment; and
 - Whether the overpayment was recovered in whole or in part, and if in part, the amount recovered and the remaining balance.
- Providers may also self-disclose overpayments to the MCO as indicated in Section 4.17.4 (Recoveries of Overpayments and/or Fraud) of the Agreement and 42 U.S.C. § 1320a-7k(d)(I), codifying Section 6402(a) of PPACA.
- All overpayments resulting from situations other than fraud, including self-reported overpayments to the MCO, shall be considered the MCO's property unless:
 - The HSD, OIG, CMS or its contractors, HSD's Recovery Audit Contractor, or the New Mexico Attorney General's Office, Medicaid Fraud and Elder Abuse Division (MFEAD, also commonly referred to as the Medicaid Fraud Control Unit) notified the provider that an overpayment existed;
 - The MCO fails to initiate recovery within 12 months from the date the MCO first paid the claim; or
 - The MCO fails to complete the recovery within 15 months from the date the MCO first paid the claim.

Credible Allegations of Fraud

- If, as a result of their investigation, the MCO determines the allegations appear credible, a SIU Case Summary form and all supporting documentation must be submitted to the PIU



Section 19: Program Integrity

Revision dates:

Effective date: January 1, 2019

within 12 months from when the MCO identifies potential fraud, or becomes aware of an allegation of potential fraud or suspicious activity, and 10 business days from completion of the MCO's investigation. The MCO shall also document the referral on Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity Report #56".

- If the PIU does not refer the matter to MFEAD or other law enforcement agency, the MCO may take whatever action it deems appropriate, including but not limited to, seeking overpayment from the provider and/or conducting educational training with the provider.
- If the PIU refers the matter to MFEAD, the PIU shall, within 10 business days, notify the MCO of such referral. Thereafter, the PIU shall attempt provide the MCO with quarterly updates based on the State Fiscal Year cycle. This is in addition to any other requirements, including payment suspension, as outlined in the Agreement, specifically 7.27.1.1. (Referrals for Credible Allegations of Fraud) of the Agreement.
- If the PIU refers the matter to MFEAD and it is not accepted or it is later returned by MFEAD, the PIU shall, within 30 calendar days notify the MCO. In such a situation, HSD, at its sole discretion and related to administrative and civil remedy available to HSD, may seek recovery against the provider for any overpayments and any refund shall be HSD's property. This is in addition to any other requirements set forth in 7.27.1 1 (Referrals for Credible Allegations of Fraud) of the Agreement.
- If MFEAD accepts the matter and brings a civil or criminal charge against the provider which results in a recovery, 7.27.12 of the Agreement shall apply.

	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
---	--------------------------------------	--

19.3. Suspension of Medicaid Payments for Credible Allegations of Fraud

All providers are required to comply with PPACA's program integrity requirements and its corresponding Federal regulations. This includes 42 CFR 455.23 which requires payment suspension of pending investigations when the OIG has verified, on a case-by-case basis, that there is a credible allegation of fraud. In addition to the requirements set forth in 7.27.11 (Referrals for Credible Allegations of Fraud) of the Agreement:

- The OIG will provide written notice of provider payment suspension, in whole or in part, as follows:
 - Notice to MFEAD;
 - Notice to the MCO to impose suspension of payments to the provider; and
 - Notice to the provider within five calendar days, or 30 calendar days if requested by law enforcement, in writing requesting a delay in sending the notice.
 - Law enforcement's request to delay sending notice may be renewed in writing up to twice and in no event may exceed 90 days.
 - In such instances, the PIU will notify the MCOs in writing that an initial delay has been requested and when 20 calendar days after law enforcement's request has been rescinded or the 90 days has passed, advise the MCOs whether payment suspension should be imposed in whole or in part.
- The MCO shall adjudicate the provider's suspended claims as part of their regular course of business and track the total amount(s) suspended. These amounts shall be reported to the PIU quarterly and updated through ad hoc reporting, as requested.
- The MCO shall continue the suspension of payments, in whole or in part, until further notified in writing by the PIU to release suspended funds. Release of funds will be authorized when law enforcement agencies, such as MFEAD, determine that there is insufficient evidence of fraud by the provider; or legal proceedings, to include any type of administrative or civil action, either by MFEAD or HSD, related to the provider's alleged fraud are completed. The MCO shall release funds as directed within 10 business days of the date of release authorization.

	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
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19.4. Adverse Action Reporting

Federal regulations, specifically 42 CFR 1002.3(b)(3) requires a state to report all adverse actions taken on provider applications in the Medicaid program directly to the Federal Department of Health and Human Services, Office of Inspector General (DHHS/OIG). Adverse actions that must be reported include a denial of credentialing or enrollment of a provider when the denial is due to concerns other than fraud, such as integrity or quality, or termination. For entities that are not natural persons, the information required includes those individuals that have control of, ownership interest in, or managing employees of the business entity. Examples of conduct that would constitute reporting to HSD (the PIU and the MAD) include providers that are denied enrollment or termination:

- As a result of adverse licensure actions, e.g., providers who are reported to the Medicare Exclusion Database, DHHS/OIG/General List of Excluded Individual Entities;
- Due to the engagement of fraudulent conduct;
- Due to abuse of billing privileges (e.g., billing for services not rendered or unnecessary Medical services);
- Due to misuse of their Medicaid provider billing number;
- Due to falsification of information on enrollment application or information submitted to maintain enrollment;
- Due to continued billing after suspension or revocation of the provider's professional licensure or certification;
- Based on a State and/or Federal exclusion; or
- Due to falsification of medical records which support services billed to Medicaid.

The MCO is directed to notify the PIU Manager and the MAD Provider Enrollment unit in writing of identified provider adverse actions within five business days from the date the adverse action was taken. An email is acceptable.

The MCO is required to develop policies and procedures for reporting all adverse actions taken on provider applications in accordance with this provision and in accordance with HSD's requirements set forth in 42 CFR 1002.3(b)(3).

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
--	--------------------------------------	--

The MCO is required to document and report all adverse actions taken on providers on Report 56 pursuant to the "Centennial Care Reporting Instructions Program Integrity-Report #56".

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
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19.5. Recipient Explanation of Medical Benefits

The MCO is required to develop and implement policies and procedures for verifying with managed care beneficiaries whether billed services were received through Recipient Explanation of Medical Benefits' correspondence verification process and procedures as set forth in 42 CFR 455.20.

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 19: Program Integrity	Revision dates: Effective date: January 1, 2019
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19.6. Fraud, Waste and Abuse Compliance Plan

The MCO is required to have a written Fraud, Waste and Abuse Compliance Plan ("Compliance Plan") per 4.17.3 of the Agreement. The Compliance Plan must contain procedures designed to detect and prevent fraud, waste and abuse in the administration and delivery of services under the Agreement. The Compliance Plan is due to the PIU on July 1 of every State fiscal year. In addition to what is stated in the Agreement, the Compliance Plan must also contain:

- Written policies and procedures that supports the execution of the Compliance Plan to prevent and detect fraud, waste and abuse in the administration and delivery of services under the Centennial Care Program;
- Designate a Compliance Officer and Compliance Committee;
- Training and Education of the MCO's employees, contractors, and providers;
- Auditing and Monitoring;
- Responding to identified or alleged potential fraud and suspicious activities; and
- Whistleblower protection and non-retaliation policy.



Section 20: Pharmacy

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20. Pharmacy

20.1. General Information

Pharmacy Benefits: Centennial Care Programs

Prescription drugs are a benefit under the Centennial Care program to be covered by the MCOs. MCOs shall support HSD in promptly responding to public and legislative inquiries involving the design and management of the MCO's pharmacy benefit.

Preferred Drug List (PDL) and Formulary Requirements

MCOs shall comply with the NMAC 8.308.9.14 Pharmacy Services and the Pharmacy Services section of the Agreement.

Treatment Guidance for Chronic HCV Infection

MCOs shall establish a system to cover treatment of members over the age of 17 years old with active Hepatitis C infection for the appropriate amount of time that the therapy requires for the member's diagnosis. The system will consist of:

- The approval process of properly requested treatments for members with chronic HCV infection using the Uniform New Mexico HCV Checklist for Centennial Care (See MAD 634 Attached);
- The development of a provider incentive plan to expand the number of practitioners treating HCV in New Mexico, including:
 - Incentive(s) to receive training in the treatment of chronic HCV infection;
 - Incentive(s) to begin treating such patients; and
 - Incentives for treatment of each patient;
- Not using active alcohol or drug use as screening criteria for the treatment, approval or denial process;
- Not using the specialty of the requesting provider as screening criteria for treatment, approval or denial;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 20: Pharmacy</p>	<p>Revision dates:</p> <p>Effective dates: January 1, 2019</p>
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- Referral of all members to a community health worker, Care Coordinator, or MCO specialty pharmacist at the time of a drug treatment request for guidance and treatment compliance;
- Quarterly data submission concerning number of requests, approvals, and denials by fibrosis stage (or equivalent) and genotype for all treatment requests;
- Sending a representative to attend quarterly meetings with other MCOs and MAD representatives as part of the ongoing HCV workgroup to review current data and recent guidance revisions and propose evidence-based future revisions to treatment guidelines;
- A comprehensive plan of outreach to the MCOs' referring providers requesting oral drug treatment for chronic HCV-infected patients;
- A comprehensive plan to expand HCV case finding efforts and screening efforts; and
- A comprehensive plan to expand HCV screening efforts to conform to USPSTF/CDC/ American Association for the Study of Liver Diseases (AASLD)/ Infectious Diseases Society of America (IDSA) guidelines.

MCOs are to approve properly requested treatments for the following Centennial Care members with chronic HCV infection:

- All members over age 17, all HCV genotypes, with a positive Hepatitis C RNA level;
- In all cases, the MCOs shall ensure (using the AASLD/IDSA guidelines) that each treatment request is appropriate with respect to:
 - HCV genotype and viral load;
 - Drug dose(s) and duration(s). The MCO's preferred formulary agent may be given preference if the level of evidence and effectiveness (as measured by Systemic Vascular Resistance) is equal or greater, and no drug interactions are of concern;
 - The presence or absence of advanced fibrosis or cirrhosis. For the purpose of making treatment decisions using the AASLD/IDSA guidance, "cirrhosis" can be considered to be present if any of the following are present:
 - APRI \geq 1.0;
 - Fib-4 \geq 3.25;

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 20: Pharmacy</p>	<p>Revision dates:</p> <p>Effective dates: January 1, 2019</p>
--	------------------------------------	--

- Transient Elastography Score \geq 12.5 kP (F4 equivalent);
 - Fibrotest \geq 0.73 (F4 equivalent) OR Fibrometer with F4 predominance;
 - Radiographic imaging or physical exam findings consistent with cirrhosis; and
 - Liver biopsy confirming a METAVIR Score of F4.
- Prior HCV treatment experience:
 - Plans may require resistance-associated substitutions testing, based on AASLD guidance.
- Guidance regarding lost or stolen medications:
 - MCOs shall use the same criteria currently used for refills of other lost or stolen medications; and
 - MCOs shall use Care Coordination and other functions to minimize this occurrence.
- Guidance regarding requests for off-label, experimental, and other forms of treatment that are not specified in the guidelines:
 - MCOs shall initiate a peer to peer consultation with the requesting physician to further understand the request and its rationale; and
 - MCOs shall present the case to Project ECHO before issuing a denial.
- Note that a "properly requested treatment" as defined above means that:
 - The Uniform Checklist form is completed fully as directed and submitted;
 - Necessary lab data and copies of medical records are attached; and
 - The requested drug(s), dose(s), and length of treatment are consistent with AASLD/IDSA guidance as written (the level of evidence in the guidance should not be considered relevant to length of treatment decisions). If not consistent, MCOs shall provide an appropriate alternative.
- MCOs are granted the option to expand their treatment criteria beyond these guidelines (e.g., to those 17 years of age and under), with advance notice to and approval by MAD.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 20: Pharmacy</p>	<p>Revision dates:</p> <p>Effective dates: January 1, 2019</p>
--	------------------------------------	--

Community Pharmacy Reimbursement

- MCOs shall ensure that reimbursement to community-based pharmacies realistically reflect buying power, buying volume, and price negotiating potential. MCOs must ensure that the Maximum Allowed Cost (MAC) for ingredient cost generic drugs for community-based pharmacies is no lower than the current National Average Drug Acquisition Cost (NADAC) listed for the NDC for the drug item. The dispensing fees will be paid in accordance with the terms of the applicable pharmacies' contracts.

Where there is no NADAC price available, such as for certain OTC drug items, certain generic drugs that have few manufacturers, and some repackage products, the MAC must be no lower than the published Wholesaler’s Average Cost (WAC) listed for the NDC plus 6%. The WAC must come from a published national pharmacy pricing source such as Medispan or First Data Bank that is not associated with the MCO or PBM. This pricing methodology for certain OTC drug items aligns with the State's reimbursement structure under Medicaid FFS. Such pricing is in effect only for drug items that do not have a NADAC price available.

If the pharmacy submits an ingredient cost less than NADAC (or the WAC plus 6% when applicable), then the MCO's PBM may use that lower submitted amount as the ingredient cost.

- A community-based pharmacy is a pharmacy that has the following characteristics:
 - Is open to the public for prescriptions to be filled, regardless of the facility or practice where the prescription was written. This includes multi-site pharmacy operations and franchises whose locations are in New Mexico;
 - Is located in New Mexico or near the state border, if the border town is a primary source of prescription drugs for Centennial Care members residing in the border area;
 - Is not government-owned, not hospital-owned or hospital-based, not an extension of a hospital, not owned by a corporation owning hospitals, and not an extension of a medical practice or specialty facility;
 - Is not owned by a corporate chain with stores outside of New Mexico;



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019

- Is not a mail order pharmacy; and
- Is not part of a national network of pharmacies or specialty pharmacies, including those primarily used for supplying IV admixtures.
- A list of pharmacies to which this section of this policy applies is included at the end of this policy. HSD develops and maintains the criteria for inclusion on the list and applies only to community based pharmacies that participate in the MCOs' Centennial care network. Inclusion of a pharmacy on the list does not mandate inclusion of the pharmacy in the MCOs' Centennial Care network. This does not supersede any credentialing requirements established by the MCO or its PBM. Pharmacies on the list that are not contracted for participation in the MCOs' Centennial Care network will be subject to the MCOs' out-of-network payment rules.
- The MCO is not obligated to adjust claims retroactively based on changes made by HSD/MAD to the list.
- Calculation of Payment:
 - A pharmacy cannot be required to submit a dispensing fee on the claim, nor shall the payer use a submitted dispensing fee to limit payment. MCOs must ensure that the contracted dispensing fee is used in the payment calculations; and
 - MCOs must pay the Administration fee, compounding or assembling fee, consultation fee, and/or prescribing fee when specifically established by MAD, such may be done for Naloxone and combined hormonal and injectable contraceptives. Currently, these add-on payments apply primarily to injections and Naloxone kits.
- Updating Prices:
 - NADAC prices (or WAC prices plus 6% for OTC drug items) must be implemented within seven calendar days of NADAC price changes. If a price increase is not made within seven calendar days, MCOs must ensure that pharmacy claims are adjusted to reflect the price increase for claims that were not paid at the increased price. A price decrease cannot be implemented retroactively.
 - For MAC prices determined by an MCO (other than NADAC and WAC plus 6%), the MCO must ensure all MAC payment levels are reviewed, at a minimum, once per week. If there is a price increase that took place during the week that resets the MAC price, an increase must be implemented within seven calendar days. If a price increase is not

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 20: Pharmacy</p>	<p>Revision dates:</p> <p>Effective dates: January 1, 2019</p>
--	------------------------------------	--

made within seven calendar days, the MCO must ensure that paid pharmacy claims are adjusted to reflect the price increase, if they were not paid at the increased price. A price decrease cannot be implemented retroactively.

- MAC prices must be established by evaluation a range of prices from sources with prices available in New Mexico. Documentation must be retained on how the price was selected and how it was determined that the price was available in New Mexico. If an MCO selects the lowest price available, documentation must be maintained showing that the source of the MAC price is available from wholesalers in New Mexico. Short-term, special deal prices cannot be used to set a MAC price at the lowest available price.

MCOs must cover flu shots, including the booster-enhanced flu shots for members when prescribed for recipients 65 and older and for other conditions per CDC seasonal recommendations.

- MCOs must follow MAD direction regarding the minimum amount of information that must be reported back to the pharmacy on a price challenge. When a MAC price challenge is made on the basis of failing to update a price within the applicable timeframes, and a pharmacy "wins" the challenge, MCOs must ensure that all pharmacy claims that were underpaid, due to the lack of a timely update, are adjusted.
- MCOs must require that if the pharmacy does not "win" the challenge, the response to the pharmacy shall state: the drug price that is in effect on the date of service; the date that the price was established as the MAC price; if the MAC price has subsequently changed since the date of the prescription and the current MAC price; the basis of that price (i.e., how the price was established); the NDC if the price is based on specific NDC; and how they concluded the price was available in New Mexico.
- MCOs must accept the price challenges directly from the pharmacy if the MCO's PBM is setting the price unless the pharmacy contract with the Pharmacy Services Administration Organization (PSAO) requires challenges to go through the PSAO, in which case the MCO must require the PSAO to forward challenges to the MCO within three business days of receipt from the pharmacy, and require the PSAO to forward any response to the pharmacy within three business days of receipt from the MCO.
- For a claim recoupment or payment reduction made more than seven calendar days after initial payment, a provider must be notified about the reason for the recoupment or reduction, the amount of the recoupment or reduction, and given an opportunity to



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019

appeal or file a grievance. There is no fair hearing right. This requirement does not apply if the pharmacy is reversing or rebilling the claim that results in a recoupment or payment reduction.

- If the pharmacy contract with the PSAO requires that notice of payment recoupment or reduction go through the PSAO, the MCO must require the PSAO to forward such notices including language regarding the opportunity to appeal the pharmacy within three business days of receipt from the MCO and the PSAO to forward any response to the MCO within three business days of receipt from the pharmacy.

MCO Participation in the DUR Board and Submission of a DUR Annual Report

MCOs shall take part in a DUR program that complies with the requirements set forth in 42 C.F.R. § 438.3(s) and 42 CFR Part 456 Subpart K, and Section 1927(g) of the Social Security Act, to ensure prescriptions are appropriate, medically necessary, and minimize the potential for adverse medical results. MCO representation on the DUR Board shall consist of one physician and one or two pharmacists.

DUR Reporting Requirements:

MCOs are contractually responsible for providing outpatient drug benefits and for conducting utilization review activities to promote the delivery of quality medically necessary care in a cost effective and programmatically responsible manner. To ensure all areas of section 1927(g) of the Act are met, MCOs must provide a detailed description of their DUR program activities to the State on an annual basis.

MCOs are required to take part in a DUR program and as part of this program, per CMS requirements, each MCO will be required to submit a DUR report to HSD that will be submitted to CMS. The report template is provided by CMS and at minimum shall contain the following:

- A description of the nature and scope of the prospective and retrospective drug review program;
- Detailed information on the specific criteria and standards in use;
- A summary of the educational interventions used and an assessment of the effect of these interventions on the quality of care; and



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019

- An estimate of the cost savings generated as the result of the program.

For your reference, the following are links to the CMS website for previous DUR reports:

All States:

<https://www.medicaid.gov/medicaid/prescription-drugs/drug-utilization-review/annual-reports/index.html>

New Mexico:

https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/2016_New_Mexico_DUR.pdf

MCO requirements regarding the Drug Rebate Analysis and Management System (DRAMS) and drug rebate dispute resolution

HSD's PBM will continue to send drug rebate invoices to manufacturers based on the encounter data for pharmacy and medical claims submitted by the MCOs. HSD's PBM will receive copies of the manufacturers' checks. If the manufacturer does not pay the invoice in full because the manufacturer disputes some of the data on the invoice, HSD's PBM will refer the manufacturer dispute to the appropriate MCO staff.

Typically, when the manufacturer disputes the invoice based on incorrect data on the claims, the manufacturer will request claim level detail (CLD). HSD's PBM will send the CLD to the manufacturer.

After the manufacturer reviews the CLD, the manufacturer may issue a dispute in the form of an email or letter, and request that the payer review the claims.

When a dispute is reported to the MCO, the MCO is responsible for reviewing their pharmacy claims data to determine if the data needs to be corrected or if the data is correct. This entails reviewing claims and possibly contacting pharmacy and medical providers to obtain information to resolve the dispute. The MCO must report the resolution of the dispute to HSD's PBM within 30 calendar days from the date of receiving the notice of the dispute.

A smaller number of disputes are initiated after the manufacturer has already paid the invoice. These disputes will be handled in the same manner as other disputes.



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019

HSD's PBM will review the MCO pharmacy and medical drug claims data prior to printing invoices in an attempt to minimize disputes. Often, for specific drug items, reporting the correct number of units is a common problem and the correction may be obvious to HSD's PBM. In such cases it will make the change prior to printing invoices. Usually, the problem occurs when the standard billing units differ from the units that CMS expects to be used on the rebate invoices. A problem also may occur when an MCO allows a provider to bill incorrect units. HSD's PBM will notify an MCO of any situation where the MCO continues to make the same error in data and the MCO will be required to implement corrections in their processing of claims.

Common Dispute Reasons

Disputes frequently result from recurring circumstances and often for the same drug items each quarter. When the error that will likely lead to a dispute originates with the provider and the MCO does not detect the error when processing the claim, the MCO will be asked to correct their claims processing editing to avoid continual disputes.

The following sections identify the most common reasons for disputes.

Unit Type Discrepancy

A provider bills a claim utilizing a unit type that differs from the unit type that was utilized in calculating the rebate. Most claims processing systems allow providers to utilize only three unit types when billing claims. Common claim processing system unit types:

- Each (caps, tabs, kits, and vials)
- Milliliters (liquids)
- Grams (solids)

CMS has eight unit types for claims:

- AHF (refers only to injectable Anti-Hemophilic Factor units)
- CAP (capsule)
- SUP (suppository)
- GM (grams)



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019

- ML (milliliter)
- TAB (tablet)
- TDP (transdermal patch)
- EA (each, refer to drugs not identifiable by any other unit type as given in program instructions)

Staff of HSD's PBM will convert the common claims processing unit types before preparing manufacturer invoices. If a dispute occurs based on unit conversion or for units that were not converted, HSD's PBM will make the correction in order to resolve the dispute.

If the unit type appears to be incorrect on the original encounter claim, the dispute will be sent to the MCO DRAMS contact for resolution.

Data Entry Errors Regarding the Quantity

Incorrect quantities are sometimes entered on the claims by the provider. If the MCO does not detect the incorrect quantities, this can cause discrepancies with the number of units shown as dispensed on the claim.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data and determine if the provider billed incorrectly. This will entail looking at the claim; contacting the provider and requesting what the units represent (ML, GRAMS, and EACH). If it is an "each", determine what the "each" represents (CAP, TAB, kits or vials). If the claim was billed incorrectly, the provider must adjust the claim with the correct units.

Decimals

When the drug strength does not equal a whole number, or the units of measure or package size has a decimal in the units, a decimal point in the units could mean a provider error.

If the MCO does not detect the incorrect quantities, this can cause discrepancies because use of a decimal point may be illogical for many unit types for drug items.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the

	Section 20: Pharmacy	Revision dates: Effective dates: January 1, 2019
---	-----------------------------	---

provider if the units are unusual and the MCO DRAMS contact cannot tell whether the provider's units are correct or incorrect.

Units or Quantities Appear Inconsistent

If the units billed for a particular NDC are inconsistent with the number of prescriptions, the pharmacy reimbursement or lowest dispensable package size, the drug manufacturers will question the amount dispensed, if it appears to be an unexpected amount.

In resolving this type of dispute, the MCO DRAMS contact should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the provider if the units are unusual and the MCO DRAMS designate cannot tell whether the provider's units are correct or incorrect.

Terminated/Invalid NDCs

Terminated NDCs (dispute code N) are those products where the shelf life for the last lot produced has expired. Per CMS guidelines, the affected manufacturer or labeler is required to submit pricing data and pay rebates for four quarters past the termination date, but only for claims with a date of service prior to the termination date.

HSD's PBM will contact the manufacturer to obtain the termination date and determine whether the date has been provided to CMS. If advised that a termination date has been sent to CMS and a sufficient amount of time has elapsed since that submission (two quarters), HSD's PBM will provide the MCO DRAMS contact staff with a list of the providers involved (i.e., those with the most claims for the drug and quarter in question). The MCO DRAMS contact must notify the providers. If the provider has the product on the shelf, they will need to provide the lot number and expiration date and provide the information to staff of HSD's PBM.

Affected claims must be checked to identify all DOS that fall after the termination date. For those claims, an adjustment must be made. The provider must adjust the claim if the incorrect NDC code was used.

State Units Exceed Expected Sales/No Record of Sales in the State

Manufacturers have a threshold on their NDC numbers and if they hit that threshold they will dispute claims based on units exceed expected sales. They also will dispute if they show no record of sales of their product within the state.

 <p>HUMAN SERVICES DEPARTMENT</p>	<p>Section 20: Pharmacy</p>	<p>Revision dates:</p> <p>Effective dates: January 1, 2019</p>
--	------------------------------------	--

In resolving this type of dispute, the MCO DRAMS contact should determine if the provider used the NDC code. Sometimes the provider can show they did order an item from out of state or have other documentation that their billing was correct. The MCO must obtain documentation from the provider of purchase, such as an invoice from their wholesaler with the NDC in question and the amount purchased. This must be forwarded to HSD’s PBM so that it may provide the information to the drug manufacturer when requested. The provider must adjust the claim, if the incorrect NDC code was used originally.

Inaccurate NDC

A pharmacy or medical provider may submit a claim in which the NDC billed is not the NDC dispensed. In resolving this type of dispute, the MCO should contact the provider and determine if they really used the NDC code reported.

The provider must adjust the claim if the incorrect NDC code was used.

Communicating with HSD’s PBM on Disputes and Correcting Errors

The MCO is to notify HSD’s PBM of claims on which the units were incorrect. HSD’s PBM will enter a comment into DRAMS that the units were incorrect and that the MCO is working on adjustments. HSD’s PBM will notify the manufacture regarding the status of the dispute.

HSD’s PBM cannot change the units on a claim, therefore, it is necessary for the MCO to have the provider adjust the claim. When the encounter data is adjusted, the DRAMS system will back out the incorrect quantity and issue new invoices with the new quantity as a prior quarter adjustment.

If the MCO verifies that some of the disputed quantities are correct, the MCO must notify HSD’s PBM. HSD’s PBM will enter a comment into DRAMS that the units were correct and state how the quantity was verified such as, a call to the provider. HSD’s PBM will notify the manufacturer. The manufacturer may request further documentation such as an invoice from the provider. When further documentation is requested, HSD’s PBM will notify the MCO who will be responsible for obtaining the documentation.

MCO Compliance with the PBM Regulation Act

The MCO will ensure the PBMs are in compliance with the requirements outlined in the PBM Regulation Act. The MCOs shall ensure they are monitoring the PBMs’ performance on an

 <p>HUMAN SERVICES DEPARTMENT</p>	Section 20: Pharmacy	Revision dates: Effective dates: January 1, 2019
--	-----------------------------	---

ongoing basis and the applicable requirements outlined in the Agreement 7.14: Major Subcontractors and Subcontractors are followed.



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019



Uniform New Mexico HCV Checklist

PATIENT NAME: _____ DOB: _____

1. DIAGNOSIS: [] Chronic Hepatitis C Infection, Genotype _____ Subtype (if applicable) _____ (attach results), HCV RNA Level within the past 6 months: Level: _____ Date: ____/____/____ (attach results)

2. ADDITIONAL REQUIRED LABS (within 3 months of request- please attach results)

[] AST, [] ALT, [] Bilirubin, [] Albumin, [] INR, [] Platelet count, [] Hemoglobin, [] Creatinine. Also document [] HBsAg, [] anti-HBs, [] anti-HBc

3. LIVER ASSESSMENT: There are seven stages of liver changes in chronic HCV infection – no liver fibrosis (F0), increasing levels of fibrotic change (F1, F2 and F3), cirrhosis (F4), decompensated cirrhosis and hepatocellular carcinoma.

a. FIBROSIS/CIRRHOSIS ASSESSMENT: (provide information using at least one of the following methods)

Indirect markers:

APRI and FIB-4 calculation boxes with formulas: APRI = (AST Level / AST Upper Limit of Normal) x 100 / Platelet Count (10^9/L); FIB-4 = (Age (years) x AST (U/L)) / (Platelet Count (10^9/L) x sqrt(ALT (U/L)))

Imaging Study: Method Used: _____ Attach results

b. Does the patient have history, physical exam, laboratory, or radiographic imaging consistent with decompensated cirrhosis (i.e. ascites, encephalopathy, bleeding varices, etc.)? No [] Yes [] (attach relevant results and notes)

Child-Pugh Score (circle one): Class A (CTP 5-6) B (CTP 7-9) C (CTP 10-15) See table on page 2 for calculation method. If patient has decompensated liver disease (Child-Pugh B or C), it is recommended that treatment be co-managed with a gastroenterologist, infectious disease specialist or hepatologist, and that referral for transplant be strongly considered.

4. LIVER TRANSPLANT No [] Yes [] (If yes, check one): [] Transplant date _____ [] Being considered for transplant

5. Is patient TREATMENT EXPERIENCED? No [] If no, go to 6. Yes [] If yes, complete a – c below. If treatment experienced with Direct Acting Antivirals (DAA), also complete question d.

a. List regimen(s) patient has received in past including year and duration of therapy: _____

b. Did patient complete treatment regimen(s)? Unknown [] Yes [] No [] If "No," reason for discontinuation: _____

c. What was patient's response to therapy? [] Unknown [] Relapse (post treatment SVR, then elevated HCV RNA level some time later) [] Non-response (HCV RNA remained detectable after complete treatment course)

d. Have you reviewed the case with Project ECHO? Yes [] No [] If no, health plan may require Project ECHO consultation.

6. RESISTANCE TESTING (please attach results, if applicable)

Does patient have genotype 1a and Zepatier will be prescribed? No [] Yes [] If yes, order [] NSSA

7. REQUESTED MEDICATION(S)

Drug: _____ Dose: _____ Duration: _____ weeks

Drug: _____ Dose: _____ Duration: _____ weeks

[] I am agreeable to approval and use of alternative drug(s), dose(s) and/or duration(s) based on current AASLD/IDSA guidance. Please have health plan contact me with recommendations.

Comments: _____

NOTE: If you are submitting a request for treatment that is not recommended in the AASLD/IDSA guidance, please submit supporting medical literature.

8. ADHERENCE POTENTIAL [] I attest my belief that this patient is capable of full adherence to the above treatment



Section 20: Pharmacy

Revision dates:

Effective dates: January 1, 2019



Uniform New Mexico HCV Checklist

9. Important Additional Recommendations:

- (1) If patient has alcohol or illicit drug abuse history, please refer patient to addiction specialist for counseling and treatment
- (2) HIV and Hepatitis A screening including HAV Ab should be performed.
- (3) Hepatitis A and Hepatitis B vaccination series should be initiated if not already completed (and patient non-immune).
- (4) Patients being considered for retreatment after failure of initial treatment with all-oral therapy should be considered for presentation to Project ECHO (attach notes).

Child-Turcotte-Pugh Classification for Severity of Cirrhosis			
Clinical and Lab Criterias	Points*		
	1	2	3
Encephalopathy	None	Mild to moderate (grade 1 or 2)	Severe (grade 3 or 4)
Ascites	None	Mild to moderate (diuretic responsive)	Severe (diuretic refractory)
Bilirubin (mg/dL)	< 2	2-3	>3
Albumin (g/dL)	> 3.5	2.8-3.5	<2.8
Prothrombin time Seconds prolonged	<4	4-6	>6
International normalized ratio	<1.7	1.7-2.3	>2.3
<p>*Child-Turcotte-Pugh Class obtained by adding score for each parameter (total points) Class A = 5 to 6 points (least severe liver disease) Class B = 7 to 9 points (moderately severe liver disease) Class C = 10 to 15 points (most severe liver disease)</p>			



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

21. Manual Acronyms

The following is a list of acronyms used throughout the document.

AAAHC	Accreditation Association for Ambulatory Health Care
AASLD	American Association for the Study of Liver Diseases
ABCB	Agency Based Community Benefit
ABP	Alternative Benefit Plan
ADHD	Attention Deficit/Hyperactivity Disorder
ADL	Activities of Daily Living
AHU	Administrative Hearing Unit
ALJ	Administrative Law Judge
ALTSD/ADRC	Aging and Long Term Services Department, Aging and Disability Resource Center
APS	Adult Protective Services
ARTC	Accredited Residential Treatment Center
BH	Behavioral Health
BHSD	Behavioral Health Services Division
BISF	Brain Injury Services Fund
BLN	Business Leadership Network
BRCA	Breast Cancer Susceptibility Gene
BSC	Behavior Support Consultant
CAHPS	Consumer Assessment of Healthcare Providers and Systems



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

CAP	Corrective Action Plan
CB	Community Benefit
CBC	Criminal Background Check
CBMA	Community Benefit Member Agreement
CBSQ	Community Benefit Service Questionnaire
CCL	Care Coordination Level
CCP	Comprehensive Care Plan
CCU	Care Coordination Unit
CDC	U.S. Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHR	Community Health Representative
CHW	Community Health Worker
CIA	Client Individual Assessment
CIU	Client Information Update
CLD	Claim Level Detail
CNA	Comprehensive Needs Assessment
COE	Category of Eligibility
COR	Consolidated Online Registry
COTA	Certified Occupational Therapy Assistants
CPR	Cardiopulmonary Resuscitation
CPS	Child Protective Services
CRI	Community Reintegration
CSA	Core Service Agencies



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

CTA	Community Transition Agency
CYFD	New Mexico Children, Youth and Families Department
DD	Developmentally Disabled
DDW	Developmental Disabilities Waiver
DHHS/OIG	U.S. Department of Health and Human Services, Office of Inspector General
DHI	Department of Health Improvement
DME	Durable Medical Equipment
DMZ	DMZ is short for DeMilitarized Zone and is software/web page for the transmission and storage of data.
DOH/OSAH	Department of Health's, Office of School and Adolescent Health
DOS	Dates of Service
DRAMS	Drug Rebate Analysis and Management System
DSP	Direct Support Professionals
DTE	Difficult to Engage
DVR	Division of Vocational Rehabilitation
DWS	Department of Workforce Solutions
EOB	Explanation of Benefits
EOR	Employer of Record
EPSDT	Early Periodic Screening, Diagnostic, and Treatment
EQRO	External Quality Review Organization
EVV	Electronic Visit Verification
FFS	Fee for Service



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

FHB	Fair Hearings Bureau
FMA	Financial Management Agency
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
Geo/Access	Geographical Access
HCBS	Home and Community Based Services
HCV	Hepatitis C Virus
HHA	Home Health Agency
HHR/HRU	High Health Risk/High Resource Utilization
HNF	High Nursing Facility
HRA	Health Risk Assessment
HSD	New Mexico Human Services Department
I/T/U	Indian Health Services, Tribal Health Providers, and Urban Indian Providers
IADL	Instrumental Activities of Daily Living
ICF IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ID/RC	Intellectual Disability/Related Condition
IDEA	Individuals with Disabilities Education Act
IDSA	Infectious Diseases Society of America
IDT	Interdisciplinary Team
IHS	Indian Health Service
IPoC	Individual Plan of Care
ISD	Income Support Division



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

ISP	Individual Service Plan
JAN	Job Accommodation Network
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LISW	Licensed Independent Social Worker
LMFT	Licensed Marriage and Family Therapist
LMSW	Licensed Master Social Worker
LNF	Low Nursing Facility
LOC	Level of Care
LOD	Letter of Direction
LOI	Letter of Interest
LPAT	Licensed Practicing Art Therapist
LPC	Licensed Professional Counselor
LPCC	Licensed Professional Clinical Counselor
LPN	Licensed Practical Nurse
LRI	Legally Responsible Individual
LTC	Long Term Care
LTSS	Long Term Services and Supports
LTSSB	Long Term Services and Supports Bureau
MAC	Maximum Allowed Cost
MAD	Medical Assistance Division
MCO	Managed Care Organization
MCO/UR	Managed Care Organization/Utilization Review



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

MDS	Minimum Data Set
MF	Medically Fragile
MFCMP	Medically Fragile Case Management Program
MFEAD	New Mexico Medicaid Fraud and Elder Abuse Division
MFW	Medically Fragile Waiver
MH	Mental Health
MMIS	Medicaid Management Information System
MSDS	Material Safety Data Sheets
NADAC	National Average Drug Acquisition Cost
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NMAC	New Mexico Administrative Code
NMSA	New Mexico Statute Annotated
NOA	Notice of Allocation
NOME	Not Otherwise Medicaid Eligible
NPI	National Provider Identifier
OT	Occupational Therapy
OTC	Over the Counter
PASRR	Preadmission Screening and Resident Review
PCMH	Patient Centered Medical Home
PCO	Planning Center Online
PCP	Primary Care Physician/ Primary Care Provider
PCS	Personal Care Services



Section 21: Manual Acronyms

Revision dates:

Effective dates: January 1, 2019

PDL	Preferred Drug List
PFOC	Primary Freedom of Choice
PH	Physical Health
PHI	Protected Health Information
PIPs	Performance Improvement Projects
PIU	Program Integrity Unit
POC	Plan of Care
PPA	Provider Participation Agreement
PPACA	Patient Protection and Affordable Care Act
PRF	Payment Request Form
PSA	Prostate-Specific Antigen
PSAO	Pharmacy Services Administration Organization
PT	Physical Therapy
PTA	Physical Therapy Assistants
QA	Quality Assurance
QI	Quality Improvement
RFA	Request for Administrative Action
RFI	Request for Information
RHC	Rural Health Clinic
RN	Registered Nurse
RTM	Return to Member
SB	Support Broker
SDCB	Self-Directed Community Benefit



Section 21: Manual Acronyms

Revision dates:

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SIER	Self-Identified Error Resubmission
SIU	Special Investigative Unit
SLP	Speech Language Pathologist
SLT	Speech and Language Therapy
SMEs	Subject Matter Experts
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SOC	Setting of Care
SOE	Summary of Evidence
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	Service and Support Plan
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TB	Tuberculosis
TBI	Traumatic Brain Injury
TFC	Therapeutic Foster Care
TPA	Third Party Assessor
UB	Universal Billing
UM	Utilization Management
USPSTF	United States Preventive Services Task Force
VAS	Value Added Services
VBP	Value Based Purchasing



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WAC

Wholesaler's Average Cost