

HEALTH CARE
AUTHORITY

Medical Assistance Division

Managed Care Policy Manual

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1. General Provisions

1.1. General Information

The purpose of the Managed Care Policy Manual (the Manual) is to provide a reference for the policies established by the New Mexico Health Care Authority (HCA) for the administration of the Turquoise Care Medicaid Managed Care program and to provide direction to the Managed Care Organizations (MCOs) and other entities providing services under Managed Care.

These policies establish general operating procedures to assist in the management of the managed care program. This Manual should be used as a reference and 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 are not all inclusive. Provisions for specialized behavioral health services are defined in the Behavioral Health Policy and Billing Manual available on the MAD website at Behavioral Health Policy and Billing Manual | New Mexico Health Care Authority (state.nm.us)

These policies will be reviewed and updated on a regular basis, and HCA reserves the right to change, modify, or supersede any of these policies and procedures with or without notice at any time.
The Manual may be viewed or downloaded from MAD's home page website at www.hca.nm.gov.
A summary list of the policy revisions will also be posted online each year. If there is a conflict between the Manual and the Agreement or NMAC rules, the Agreement and NMAC rules control. The Manual does not create any rights that are not contained in the Agreement or NMAC rules.

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

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

2. Provider Network

2.1. Service Termination and Provider Closure

Anticipated changes in the MCO provider network shall be reported to the Medical Assistance Division (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, whichever comes earlier. Unexpected changes shall be reported within five calendar days of the MCO's knowledge about the change.

Anticipated Changes	
Notification	30 Calendar Days maximum
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 maximum
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 HCA 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, or when the MCO learns through means other than provider notification, of its intent to change or terminate a service(s). 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, which may result in the need for members to transition from one service provider to another.

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 HCA. In the event HCA 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 HCA 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 HCA Contract Manager. Transition Plan B will be submitted by fax or via a secure website as determined by the MCO and HCA. The HCA Contract Manager will review and approve the official Notification, Narrative, and Transition Plan A and will monitor and provide feedback on Transition Plan B.

If the submitted transition plan documents are incomplete, with the exception of Plan B, HCA will reject the reporting and monetary penalties may apply per Section 7.3.3.6.5 of the Medicaid Managed Care Services Agreement.

2.2. MCO Initiated Provider Network Closures and Reductions

The MCOs will submit a written request to HCA 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.
- HCA will review and provide the MCO with a written approval or denial within 10 business days.
- At HCA's discretion, the MCOs may be required to submit all transition plan documents.

2.3. Provider Monitoring

HCA/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.

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 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 Service (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.
- The MCOs should allow certified-nurse practitioners, clinical nurse specialists and certified nurse-midwives who have been granted parity with physician privileges at health facilities to admit, discharge, and authorize continued patient care.

  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 lookup 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.

  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 (adult accredited residential treatment center [AARTC], accredited residential treatment centers for youth (ARTC for youth), non-accredited residential treatment centers (RTC) and Group Homes) (referring or ordering provider in the attending field);
- 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.

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
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.

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.

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

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 lever.

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.

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"

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"

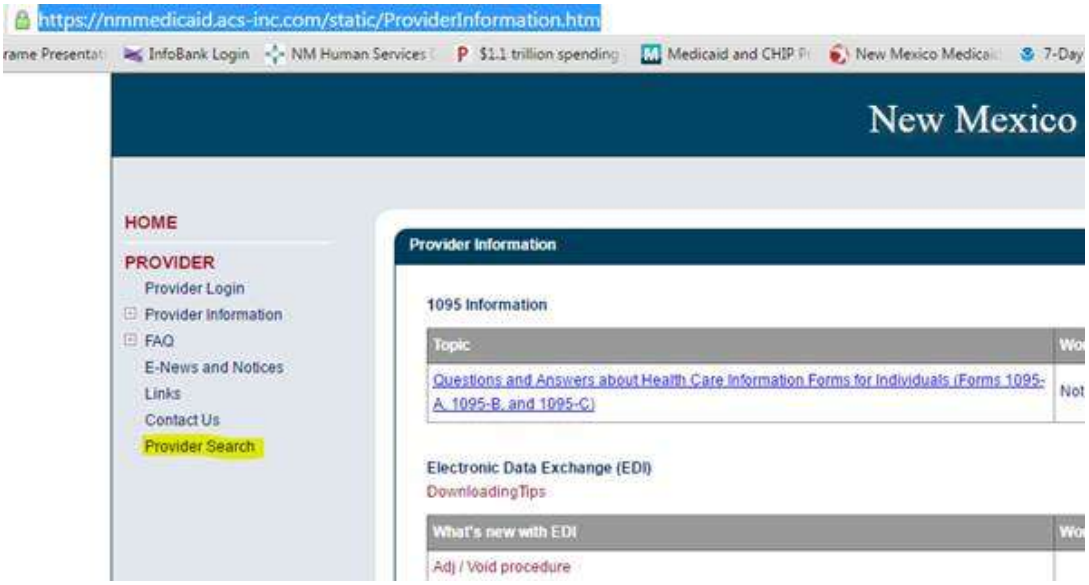
Referring Provider's NPI – 2310A (Header)/2420F (Line), NM109

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

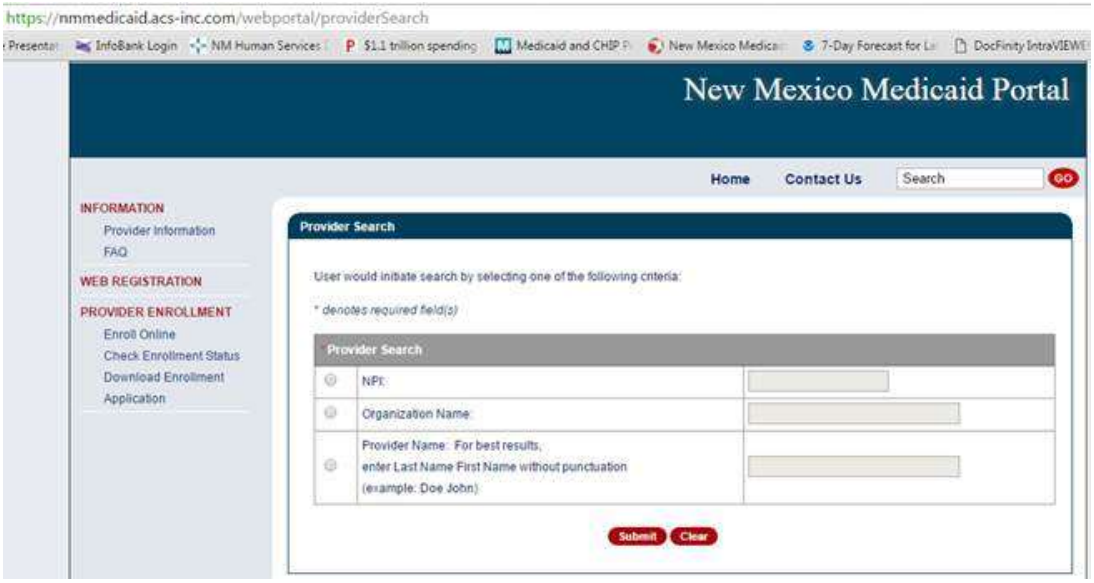
It is ultimately the responsibility of the Medicaid provider billing the service to obtain the NPI of the prescribing, referring, ordering, attending, or rendering provider and to confirm the provider's active enrollment in the Medicaid program. Each Medicaid provider will need to develop its own internal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



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



4. You will get results such as those below.



5. 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 Service 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.

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 Service Hospital or Tribal Compact facility – specialty 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.

HCA 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 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.

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, Oxygen, DME, 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.

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 Service 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

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.

  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.

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
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

Provider Type	Description
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)
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.

2.11. Appendices

2.11.1 Notification of Change in Services – Notification of Transition

2.11.2 MCO Notification to HCA of Change or Closure- Narrative for Provider/Facility

2.11.3 Transition Plan A- Overall Transition Plan Information- MCO Transition Plan for Provider/Facility

2.11.4 Transition Plan B- Member Specific Information for Provider

2.11.5 Definitions

2.11.1. Notification of Change in Services – Notification of Transition

MCO NOTIFICATION TO HCA NOTICE OF CHANGE IN SERVICES ☐

MCO NOTIFICATION TO HCA- NOTICE 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.

Transition Plans A & B Due Date:

(Due 15 calendar days after Notification)

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

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

2.11.2. Transition Plans Narrative

MCO Notification to HCA of Change or Closure

Narrative For

(Provider/Facility Name)

Date:

MCO Staff and/or Care Coordinator:

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

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

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

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

Transition issues identified

2.11.3. 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				
Closing program sends a formal letter to MCO advising				
List of affected members sent to MCO.				
List of special problems expected or associated with				
MCO letter to affected members offering assistance				
2. Network Operations				
Contracting department to complete Table A Provider Information.				
3. Transition planning				
Meeting with program or director				

	MCO task assignment	Comments	Begin Date	End Date
Complete plan to ensure program is appropriately referring and transitioning				
Progress updates of transition program.				
Template for Records Retention Completed and				
4. Communication to HCA				
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				
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				
Compile weekly report of care coordination.				
Meeting with MCO and program transition team to coordinate efforts, if				

	MCO task assignment	Comments	Begin Date	End Date
Other requirements as needed depending on circumstances of closing.				
Transition plan finalized.				

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

Signature:

_____Date: _____

2.11.4. Transition Plan B

HUMAN SERVICES DEPARTMENT

TRANSITION PLAN B
Member Specific Information
(Provider Name)
(Date)

Member Name	Social Security Number	Medicaid ID	Member Date of Birth	Guardian (if applicable)	Services currently receiving (therapy, med monitoring, PCO, etc.)	Current Provider, address, phone number, county	County in which member recieves services

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HUMAN SERVICES DEPARTMENT

TRANSITION PLAN B
Member Specific Information
(Provider Name)
(Date)

Service County Status: Rural, Urban or Frontier	Date of discharge	New Provider	Date of Transition or anticipated date	Appointment Date (for outpatient Services)	Care Coordinator and phone number (if applicable)	Special Conditions/Arrangements (Housing issues, social issues, etc.)	Special Condition/Arrangment Behavioral Health Code(s) - See Special Conditions Legend	MCO notified? (Y, N, NA)

2.11.5. Definitions

- **Certified Nurse Midwife (CNM)** means a registered nurse pursuant to the Nursing Practice Act who is licensed by the board of nursing for advanced practice and licensed by the Department of Health as a nurse-midwife.
- **Certified Nurse Practitioner (CNP)** means a registered nurse who is licensed by the board for advanced practice as a certified nurse practitioner and whose name and pertinent information are entered on the list of certified nurse practitioners maintained by the board.
- **Clinical Nurse Specialist (CNS)** means a registered nurse who is licensed by the board for advanced practice as a clinical nurse specialist and whose name and pertinent information are entered on the list of clinical nurse specialists maintained by the board.

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.

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.

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;
- 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 HCA 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 nonpayment, the provider may not bill the Member, and if a provider bills the Member for noncovered 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.

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.

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 HCA-; and
- All applicable co-payment amounts.

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 HCA 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 HCA 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 HCA 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.

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.

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 or entities designated as Care Coordination delegates.

- Conducting Health Risk Assessments (HRAs) for Members newly enrolled in Turquoise Care or Members who have had a change in circumstance or change of health condition that requires an assessment for a higher level of care and who are not currently identified for Care Coordination Level 1 or 2 services, including those with retroactive eligibility;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semiannually, annually, or upon a change in health condition that may warrant a higher level of care;
- Administer the Community Benefit Service Questionnaire (CBSQ) as applicable (see Section 4.5 CBSQ);
- Semiannual in-person visits with the Member;
- Quarterly telephone contact with the Member;
- Coordinating Member access to Covered Services as needed (e.g., scheduling appointments, arranging transportation, making referrals);
- Communicating and exchanging information with Providers;
- Comprehensive Care Plan (CCP) development and updates; and
- Targeted Health Education, including disease management (per 4.4.8 of contract), based on the Member's individual diagnosis.

MCOs may delegate care coordination functions, per 4.4.10 of the Agreement.

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 or who are Children in State Custody (CISC) members.

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 interrater reliability) to determine effectiveness and appropriateness of processes.
- Competencies will be evaluated in the following areas, but not limited to:
  - NF 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;
  - Comprehensive Care Plans (CCPs) are developed and updated on schedule in compliance with the Agreement;
  - CCPs reflect needs identified in the CNA and reassessment process;
  - CCP goals are Member centric, and agreed upon by the Member;
  - CCPs are appropriate and adequate to address the Member's needs including the need for all Community Benefit (CB) services;
  - Services are delivered in a person-centered, holistic, strength-based, and well-coordinated manner as described in the CCP and authorized by the MCO;
  - Services are appropriate to address the Member's needs; including culturally responsive treatments and supports for Native American children and youth in CYFD Protective Services (PS) custody;
  - Services are delivered;
  - Service utilization is appropriate;
  - Service gaps are identified and addressed;
  - Minimum Care Coordinator contacts are conducted;
  - Care Coordinator to Member ratios are appropriate per 4.4.5.7.1 of the Agreement;
  - 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 CCP, date of authorization of the CCP, date of initial service delivery for each service in the CCP, date of each NF LOC and needs reassessment, date of each update to the CCP, 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 NF LOC reassessment, date of comprehensive needs reassessment, and date to update the CCP;
  - Capture and track eligibility/enrollment information, NF LOC assessments and reassessments, and needs assessments and reassessments;
  - Capture and monitor the CCP
  - 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 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;
  - 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 the HCA or its designee to have remote access to case files.

4.3. Health Risk Assessment

The MCO or its delegate shall conduct HCA's standardized HRA (see Appendix 4.15.1) on all Members who are newly enrolled in Turquoise 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 0, Level 1 or Level 2.

The standardized HRA (Section 4.15.1.) will be completed for each new Turquoise Care Member within 30 calendar days of notification to the MCO of the Member's enrollment in the MCO. 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 HCA approval. Requests must be sent for approval to HCA/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.

Additionally, an HRA will be completed upon a change in the Member's health condition if the Member is not in Care Coordination Level 1 or Level 2. The HRA may be conducted by telephone or in person; HRA information must be obtained from the Member or the Authorized Representative (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 HCA 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), 1915 (c) HCBS Waiver Case Managers and Consultants, New Mexico Brain Injury Resource Center, and Centers for Independent Living. For CYFD Protective Services (PS) and/or Juvenile Justice Services (JJS) involved children/youth, the MCO or its delegate will collaborate with the assigned CYFD Permanency Planning Worker (PPW), Juvenile Probation Officer (JPO), and Community Behavioral Health Clinician (CBHC) for physical and behavioral health services. 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 "Unable to Reach" (UTR) and is assigned to CCL0. 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.

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 HRA or CNA, the Member is categorized as "Difficult to Engage" (DTE) and is assigned to CCL0. If the Member is categorized as a CCL1 or CCL2 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 (CCL0), with appropriate documentation in the Member's file. The MCO will perform quarterly claims mining for these Members and will renew attempts to reach Members if claims mining indicates a possible need for care coordination.

For Difficult to Engage (DTE – CCL0) and Unable to Reach (UTR – CCL0) Members transitioning from an inpatient level of care setting including general hospital, psychiatric hospital, skilled nursing, or residential treatment centers or who have had two (2) or more Behavioral Health readmissions within thirty (30) Calendar Days, the MCO shall make and document a face-to-face outreach attempt by a care coordinator with behavioral health experience. If those efforts are unsuccessful, the MCO shall send a letter to the Member's most recently reported address that provides information about Care Coordination, the importance of completing an HRA, and how to complete the HRA.

The MCO shall perform quarterly Data Mining Reviews (DMRs) for all Members to determine if there is a change in the Member's health status that warrants the need to reinitiate Member outreach efforts or to perform an updated HRA or CNA.

Within ten calendar days of completion of the HRA, all Members shall be informed of the need for a CNA. Members requiring a CNA shall receive contact information for the CONTRACTOR's Care Coordination unit, the name of the assigned care coordinator (if applicable), and a time frame during which the Member can expect to be contacted by the Care Coordination unit or individual care coordinator to complete the Comprehensive Needs Assessment. The MCO shall schedule a CNA within 10 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, Treat First, CARA, or JUST Health Care Coordination with other State-approved guidelines.

4.4. Comprehensive Needs Assessment

HCA's standardized 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 CCL1 or CCL2.

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. Such claims could include a positive pregnancy test, Substance Use Disorder (SUD), or Serious Mental Illness (SMI).

For Members who reside in a NF, rather than conduct an in-person 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.

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 Delegation Model.

CNAs must be performed through the utilization of the HCA standardized CNA for assessing the Member's medical/PH, BH, LTC, and social needs. MCOs may request to add additional questions to the CNA 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 HCA/MAD through the MCO's Contract Manager to the attention of the Quality Bureau Care Coordination Unit (CCU).

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, and/or other significant social support individuals, with the consent of the Member. For CYFD PS and/or JJS involved children/youth, the MCO or its delegate, will collaborate with the assigned CYFD Permanency Planning Worker (PPW), Juvenile Probation Officer (JPO), and Community Behavioral Health Clinician (CBHC) for all medically necessary services including behavioral health services. 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 HCA. 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 face-to-face in an alternate location without requesting an exception from the State under the following conditions:

- If the Member is homeless, or in a transition home or youth shelter 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 nonprofit organization center, community MH agency, food bank site, etc.;
- If the Member is receiving treatment in an out of state facility;
- If the Member is a newborn in an inpatient setting;
- If the Member is currently part of the prison or jail involved population preparing for release; or
- If the Member is in a Health Home.

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

- Complete the Turquoise Care CNA Exception Request form (MAD 601) (see Appendix 4.17.2);
- Alternate locations must be submitted to HCA 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: HCA-QB-CCU-CNA@hca.nm.gov;
- HCA 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
- Requests **will not** be reviewed or approved if submitted:
  - Via unsecure email;
  - To an email address other than HCA-QB-CCU-CNA@hca.nm.gov, 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 consideration 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, currently categorized as a CCL1 or a CCL2, refuses to participate with a CNA, the MCO will make every effort to discuss the benefits of the CNA 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 HCA-approved Care Coordination Declination Form and maintain the signed form in the Member's file (see Appendix 4.17.3). 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 who has refused Care Coordination will not be assigned to Care Coordination Level 1 or Level 2. In documented refusal circumstances, the MCO will submit a proposal to the Member outlining a basic CCP with minimum services outlined and suspend any requests for increased services/personal care hours until a CNA and NF LOC is conducted and completed.

4.5. Community Benefit Service Questionnaire

As part of the CNA process, MCO Care Coordinators must administer the CBSQ. The CBSQ/CBMA will be administered as part of the CNA, at the beginning of the CNA. 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 CBMA is not used to document the Member's refusal to complete a CBSQ.

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 MCOs must have a process in place to monitor that CBSQs and CBMAs are completed correctly and in accordance with Section 4.5 of the Managed Care Policy Manual.

The CBSQ/CBMA will be administered as part of the CNA, at the beginning of the CNA, for the following Members:

- Allocated Members receiving their first CNA, including Members who are in the process of community reintegration from a NF and Members who lost their full Medicaid Category of Eligibility (COE) and are being allocated for continuity of care.
- Annually for Members with a current NF LOC (see note about CCL3 Members below).
- Full Medicaid Members without a NF LOC who request CB services.
- Full Medicaid Members without a NF LOC who have not requested CB services but appear to meet NF LOC criteria prior to or during the CNA. MCOs must attempt to determine this through claims data or other information obtained prior to the Member's CNA including the functional needs identified in the HRA.

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

- Members who have not previously met a NF LOC and who are not requesting CB at the time of the CNA.
- Members who may meet a NF LOC for a short period of time due to a clinical episode (e.g., pregnancy).
- Members not being assessed for a NF LOC.
- Members on the DD, Mi Via, or MF Waivers (categories of eligibility [COEs] 095 and 096).
- Members in a 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.
- Members who decline Care Coordination. The Declination Form must be on file with the MCO. If a Member refuses to sign the Care Coordination Declination Form, the contractor shall document such refusal in the Member's record.

CCL2 Members:

- For all Members with CCL2 and a NF LOC, the CBSQ/CBMA must be administered at least annually or more frequently as determined by the Care Coordinator.
- For Members with CCL2 but without a NF LOC, follow the criteria above.

In any circumstances not covered by the criteria, the Care Coordinator should use his/her judgment and consult with his/her supervisor as necessary to determine appropriate use of the CBSQ. Care Coordinators should use the CBSQ as a tool to guide the discussion with the Member and/or the Member's representative to inform them of the availability of CB services.
HCA will audit CBSQ and CBMA completion to ensure that these requirements are met.

Members who wish to receive fewer PCS hours than initially authorized should discuss with their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA). In this agreement, they would specify the reduced number of hours they require and any additional comments about the reduction. Subsequently, both the agency and the Member can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment.

The request for a reduction in hours must be Member-driven. Reduction in hours should not be considered if reduction request is due to provider agency inability to staff, provider agency or caregiver coercion, or due to dereliction of duties/ poor performance of the caregiver. Members must be informed of their right to request a new or additional caregiver or new provider when available. A Member's request for a reduction in hours should not be made for temporary or otherwise short-term periods. A Member must understand the request for reduced hours will be for the remainder of their budget/care plan year. However, if the Member has a change in condition, change to natural supports, or otherwise needs to increase their hours back to the original assessed number, they may work with their Care Coordinator to do so. Any reduction of underutilization of PCS hours shall not be used as justification to reduce any future assessment of services needed by the Member.

Members must willingly agree to and sign the CBMA for the reduced PCS hours, with the MCO maintaining a record of this agreement. MCOs can then update the PCS authorization in AuthentiCare to align with the mutually agreed-upon lower number of PCS hours. In addition, the provider agency must be informed of this change in hours. This streamlined approach reduces the administrative workload on PCS agencies.

4.6. CNA Reassessments

The CNA shall be conducted at least annually for level 1 Care Coordination and at least semi-annually for level 2 Care Coordination, to determine if the CCP is appropriate for the Member and if a higher or lower Care Coordination Level 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 including changes in placement for children in CYFD PS custody.

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, Juvenile Justice Services, Behavioral Health 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 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 or in-person contact with the Member.

4.7. Comprehensive Care Plan Requirements

The MCO or its delegate shall complete the HCA's standardized CCP (see Appendix 4.17.4). 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 CCP for all Members in levels 1 and 2 of Care Coordination. The MCO or HCA-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 HCA 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 including the Individualized Planning Meeting Team for children and youth in CYFD PS custody, as needed when developing the CCP, including documentation of all attempts to engage providers and other individuals identified in the development of the CCP;
  - With the Member's consent to share information, the CCP 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);
  - Verification of all decisions made regarding the Member's needs and services, and ensures all information is documented in a written CCP;
  - The MCO or HCA-approved designee shall develop the CCP within 14 business days of completion of the initial CNA and update the CCP within 5 days of subsequent CNAs unless the Member is in a health home and/or using the Treat First model of care; and
  - 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. This information may be accepted verbally; however, it must be clearly documented in Member's file.

  - 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 and/or parent, legal guardian and/or CYFD worker's (if in CYFD Custody) 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, implementation, and/or updating the CCP are met;
- Facilitate treatment and coordinate with providers to assist the Member and his or her family and CYFD lead worker (if in CYFD custody) 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; and
- Identify, address, and evaluate service gaps to determine their cause and minimize any gaps going forward and ensuring backup 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.

- Inform each Member of his or her Medicaid eligibility status and end date and assist the Member with the process for eligibility redetermination;
- For children and youth in CYFD PS custody, inform Native American children and youth and their Permanency Planning Worker (PPW) of opportunities to receive culturally responsive treatments, interventions and supports, including those that are non-medicalized;
- 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), and
- 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.

- 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 CCP will be modified accordingly within 72 hours;
    - 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, removal from the home by CYFD or changes in CYFD 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 HCA.
  - Within five business days of completing a reassessment of a Member's needs, the MCO or HCA 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 HCA approved designee shall perform real time and ongoing Care Coordination to ensure all Members receive the appropriate care.

- CCL1 and CCL2 Members shall receive quarterly telephonic touchpoints and bi-annual in-person visits.
- 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 CCP as needed;
    - Ensure when a Member's Care Coordination Level 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. The MCO shall maintain consistent communication and contact with the assigned CYFD Permanency Planning Worker (PPW) for protective services involved children and youth, Juvenile Probation Officer (JPO) for juvenile justice involved youth, and Community Behavioral Health Clinician (CBHC) for CYFD involved children and youth;
    - Maintain and monitor the Member's CB and provide assistance with complex services;
    - Consider Member and provider input to identify opportunities for improvement, and
    - Collaborate and/or cooperate with representatives of the Independent Consumer Support System.

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

- CCL1 – 1:75
- CCL2 – 1:50

MCO or its delegates shall submit, upon request by HCA, 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 Service, 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 4.15.3 of the Agreement.

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.

4.9. Engagement of Members

HCA 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 CCPs. 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 Member 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 Member and appropriate participants of the care team. For CYFD involved clients, include the CYFD community behavioral health clinician (CBHC) and the child's PPW. This team must include the care coordinator, a management level staff of the MCO and a high-level clinician of the MCO. The Member may request one or two people to be in attendance. The intention of the meeting with the Member is to:

- Establish/discuss optimal outcome for health and safety;
- Identify the issues interfering with optimal health and safety outcomes;
- Clarify roles for each Member of the team;
- Clarify rules of engagement (who can call 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 second, and final, meeting within two weeks. Review tasks. Discuss/establish consequences of any failure to deliver on tasks. Sign contract/CCP. (Includes updates weekly and addressing ongoing/emergent issues at a bimonthly meeting.)
- Schedule updates between participants and MCO staff on a regular basis; and
- Ensure maintenance of documentation is with MCO, Member, and natural supports.

When HHR/HRU Members are identified, the MCOs will designate one point of contact and communicate that point of contact to HCA/MAD and other involved individuals. If the identified Member calls HCA/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.

4.10. MCO Care Coordination with 1915(c) HCBS Waivers: Developmental Disabilities (DD), Mi Via and Medically Fragile (MF) Waivers

The MCOs provide acute and ancillary medical and BH services to the 1915 (c) HCBS waiver 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, BH, and ancillary needs; explaining to the Member, family, and/or guardian, the Medicaid benefits that are available from the MCO, and how the MCO care coordinator can assist with coordinating services with the case manager or consultant; 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.

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

- **Developmental Disabilities Waiver (DDW) Program**

  The DDW provides an array of HCBS to help individuals with developmental and/or intellectual disabilities 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 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID) LOC. DDW individuals have a Medicaid Category of Eligibility (COE) 096.

  The DDW provides the following HCBS: behavior support consultation; case management; community integrated employment services; customized community supports; customized In Home Supports; crisis support; environmental modification; independent living transition service; intensive medical living supports; living supports; nonmedical transportation; nutritional counseling; remote personal support technology; preliminary risk screening and consultation related to inappropriate sexual behavior; adult nursing; respite; socialization and sexuality education; supplemental dental care; assistive technology; and skilled therapies (physical, occupational, and speech). 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.

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

  Mi Via is the State of New Mexico's self-directed- waiver program serving individuals who meet an ICFIID LOC. Medicaid Members served through the Mi Via waiver are referred to as "participants." Mi Via participants are identified with either COE 095 Medically Fragile or COE 096 Developmental Disability and a Setting of Care (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 Turquoise Care Self-Directed Community Benefit (SDCB) Program.

  Mi Via provides the following services: consultant; behavior support consultation; community direct support; customized community supports; in-home living supports; emergency response service; 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 (physical, occupational, and speech); specialized therapies; related goods;- nonmedical transportation; and individual directed goods and services-. Mi Via services are supplementary to EPSDT benefits for participants under the age of 21 years old.

  Mi Via waiver services and budget are outlined in the participant's Service and Support Plan (SSP). The SSPs are developed through a person-centered planning process which allows participants to select services that will help them achieve personally defined outcomes in the most integrated community setting. The SSP is created by the Mi Via participant with the assistance of their

consultant. Consultants provide information, support, guidance, and assistance to participants during the Medicaid eligibility process and afterwards during SSP development. Consultants serve to help the participant identify supports, services, and goods that meet their need for Mi Via waiver services and are specific to the participant's qualifying condition. The level of support a consultant provides is unique to the individual participant and their ability to self-direct in the Mi Via program.

- **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 Medicaid COE 095. MFW recipients meet an ICF/IID LOC, as well as established MF parameters.

  The MFW provides the following HCBS: RN case management; private duty nursing (RN, licensed practical nurse [LPN]); home health aide; behavior support consultation; customized community group supports; respite care; nutritional counseling; skilled therapies (physical, occupational, and speech) for adults; environmental modifications; vehicle modifications; individual directed goods and services; specialized therapies; 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 nonwaiver (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.

4.12. MCO Care Coordination Activities and the 1915(c) HCBS Waivers Service Plan (ISP or SSP)

- Members who transition from Community Benefits to a 1915 (c) HCBS Waiver
  - Coordination between the MCO and 1915 (c) Waiver program must be coordinated to avoid gaps in home and community-based services (i.e. Community Benefits and 1915 (c) Waiver) during the transition.

- The MCO Care Coordinator shall work proactively with the Member and Member's 1915 (c) case manager/consultant to coordinate the transition dates for the Member to move seamlessly from Community Benefits to the 1915 (c) waiver service plan.

- Members in the DD Waiver program
  - The MCO Care Coordinator shall request a copy of the approved DDW LOC packet, consisting of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) abstract (MAD 378 form) and related waiver assessments 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 packet;
  - The MCO Care Coordinator cannot make changes to the Member's DDW ISP and Budget;
  - The MCO will not complete a NF LOC on Members enrolled in the DD 1915 (c) waiver, unless the Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the Member's DDW case manager in the event of a NF long-term permanent placement;
  - The MCO will 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 Member;
  - The MCO Care Coordinator shall 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. The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for Members who are receiving HCBS through the DD waiver.
- MCO Members in the Mi Via Self Directed Waiver Program
  - The MCO Care Coordinator shall request a copy of the approved Mi Via LOC packet, consisting of the abstract (MAD 378 form) and related assessments 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 MCO Care Coordinator cannot make changes to the Member's Mi Via SSP and Budget;

- The MCO will not complete a NF LOC on Members enrolled in the Mi Via 1915 (c) Waiver, unless the Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the Member's Mi Via consultant in the event of a NF long-term permanent placement;
- The MCO Care Coordinator will 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 Member;
- The MCO Care Coordinator shall 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 and the participant's family;
- The MCO Care Coordinator shall utilize only the PH and BH portion of the MCO's CCP for Members who are receiving HCBS through the Mi Via 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 MFW case management agency 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;
  - The MCO shall ensure the MFW ISP serves as the CCP for the MF Member.
  - The MCO shall work with the MFW case management agency 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 a NF LOC on Members enrolled in the MF 1915(c) Waiver unless the Member is transitioning from the community to a nursing facility for long-term care permanent placement. The MCO shall inform the Member's MFW case manager in the event of a NF long-term permanent placement;

- The MCO will not be required to conduct a monthly/quarterly face-to-face or telephonic contact for the MF Members. The MFW case management agency 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, and
- Utilize the MFW ISP as the CCP for the MFW recipient.

4.13. MCO Care Coordination Activities for MF EPSDT (Non-Waiver) Members Case Managed by the MFW Case Management Agency

The MCOs are contracted with the MFW case management agency to continue to provide RN/case management services for those individuals (nonwaiver) who meet the MF criteria. The same MF parameters are utilized for nonwaiver Members.

For MF EPSDT (nonwaiver) clients, the MCO Care Coordinator shall:

- Request a copy of the approved MF ISP from the MFW case management agency 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.
- Not complete a NF LOC assessment on MF EPSDT Members.
- Ensure the MF ISP serves as the CCP for the MF Member.
- Work with the MFW case management agency 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 MFW case management agency 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.

4.14. Transitions from the HCA Non-Medicaid Brain Injury Services Fund to a Turquoise Care MCO

The HCA 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 will follow all care coordination requirements as applicable. The MCO may contact the HCA BISF service coordination contractor to verify the status of a Member's BISF eligibility. Upon enrollment with the MCO, all BISF service coordination requirements transfer to the MCO. 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 affect the full transition of the Member's care from the BISF to the MCO.
    - 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.
    - The MCO Care Coordinator is to acquire a copy of the BISF participant's BISF assessment and Independent Living Plan (ILP) from the BISF service coordinator to ensure their inclusion in the Member's file. These efforts are intended to preserve the history of brain injury and ensure that care needs are related to the brain injury diagnosis.
- The MCO shall receive brain injury training by the HCA, 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.

4.15 MCO Care Coordination for CARA infants and mothers

4.15.1 Care Coordination Teams

The Contractor is directed to fully delegate care coordinator functions for CARA members (infants) and mothers, as with all other perinatal members. No services shall be withheld while waiting for completion of the HRA or CNA. If the infant is in the mother's custody, infant and mother should have the same care coordinator.

Timelines

Contact with the guardian of the infant in the CARA program should occur within 24 hours of the discharge from the hospital. The HRA should be completed inpatient whenever possible and if not possible should be completed at the call done within 24-hours. CNAs should be done in the Member's home within 7 days of discharge from the hospital. Three attempts to contact the guardian should be made within the first 48 hours of discharge. If the care coordinator is unable to reach the mother and the baby is in the mother's custody, the care coordinator must contact the CARA navigation team.

Communications

The CARA care coordinators should regularly meet with CARA Member assigned pediatricians, hospitals, and home visiting agencies in their community to discuss communication challenges and processes. The care coordinator is required to submit the POC created by the hospital, to the infant's PCP (pediatrician, midwife, or family medicine provider) within 5 business days from receiving notification of a new POC. The HRA and CNA must be submitted to the PCP within 14 business days of discharge. The CARA care coordinator must create a transition plan when the CARA program ends at the one-year mark for the CARA navigation team to ensure continuity of care for the infant.
This must be completed within 60-days before the graduation date.

Reporting

The CARA infant's parent/legal guardian has the right to refuse Care Coordination for themselves and/or the infant, and the MCO care coordinator should obtain a Declination Form from the individual refusing Care Coordination in accordance with 4.4.1.5 of the New Mexico Health Care Authority Medicaid Managed Care Services Agreement. In addition, the MCO care coordinator will email the CARA DUR

Member Form (MAD 902) to the CARA navigator at CARA.CYFD@cyfd.nm.gov and DOH-CARA@DOH.NM.GOV (see Appendix 4.17.5).

4.15.2. Care Coordination Presence in Hospitals

The Contractor is directed to assign Members of their Care Coordination team to each of the following hospitals:

- University of New Mexico Children's Hospital Level IV,
- Lovelace Women's Hospital Level III,
- Presbyterian Main Hospital Level III,
- Memorial Medical Center Level II, and
- Mountain View Medical Center Level II.

To ensure all eligible CARA infants, birth mothers, and legal guardians are provided the information on the services and supports available, HCA is directing the Contractors to implement the process below:

- Assign a care coordinator to conduct in person daily rounds at each of the facilities above to identify infants admitted to the NICU and the mother/baby unit, who are eligible for care coordination through the MCO.
- The MCO care coordinator will make contact with the staff in the NICU and mother/baby unit, including both social workers and nurses, and obtain a complete list of all Medicaid Members that are currently enrolled or presumptively enrolled with the MCO.
- The MCO care coordinator will obtain a complete list of infants identified as enrolled or presumptively enrolled with the MCO and born exposed to substances and ensure that a plan of care (POC) has been written by the hospital staff and submitted through the New Mexico Healthy Families portal.

The MCO care coordinator will visit every birth mother and/or CARA infant's legal guardian identified as enrolled or presumptively enrolled with the MCO in the unit and, with consent, discuss services covered by Medicaid and services available to the Member that are not covered by Medicaid, that are available for both mother and infant. Although CARA infants are the focus of this program, every person who has birthed an infant and every infant born who is enrolled or presumptively enrolled in Medicaid should receive an in-person visit from

a care coordinator within these 5 hospitals.

If permitted, the MCO care coordinator will attend any discharge planning rounds and team meetings within the unit to make connections to staff to be fully updated on the healthcare status of mothers and infants enrolled or presumptively enrolled with the MCO.

The MCO care coordinator will inform the infant's parent/legal guardian of the full range of services and resources available and provide the name and contact information of the care coordinator assigned to the infant. Whenever possible, the Contractor shall align the mother's Care Coordination with the infant's Care Coordination, as well as any other family Members engaged in Care Coordination with the MCO, by assigning the same care coordinator to all Members of the family.

When feasible, the care coordinator will perform the Health Risk Assessment (HRA) during this initial contact. Services, supports, and resources that should be offered shall include but are not limited to the following:

- Care Coordination;
- Medicaid/Non-Medicaid Home Visiting Programs;
- Value Added Services (VAS) such as infant car seats and diapers offered by the Contractor;
- Housing supports, Supplemental Nutrition Assistance Program (SNAP), and Income Support;
- Substance use disorder counseling and Behavioral Health services, and
- Referrals and scheduling assistance with a pediatrician/Primary Care Provider (PCP) for both infant and mother.

4.16 MCO Care Coordination for Prenatal and Postpartum Members

The Contractor must offer the Full Delegation Model of Care Coordination for all prenatal and postpartum Members, but this Full Delegation Model does not require a specific Value Based Purchasing (VBP) level. The Contractor may offer the Full Delegation Model within Level 1, Level 2, or Level 3 VBP arrangements. If an MCO offers the Full Delegation Model under a Level 3 (Full Delegation), VBP arrangements must outline a payment arrangement for the full delegation of Care Coordination and other requirements associated with improving quality and health outcomes.

The Assignment to other than a model of full delegation may occur only with HCA prior written approval. The Contractor must have a reasonable justification for not placing the Member in a full

delegation model and may request an exception through the Contract Manager in an encrypted email or password protected document as an attachment to an email and must include the following:

- Member name;
- Member Medicaid ID;
- Member DOB;
- Member address;
- Reason for requesting the exception;
- Completion date of HRA/CNA;
- CCL level (if applicable), and
- Describe how member will receive Care Coordination Services from the MCO.

4.17. Appendix

4.17.1 Health Risk Assessment (HRA)

4.17.2 MAD 601: Turquoise Care CNA Exception Request

4.17.3 MAD 869: Care Coordination Declination Form

4.17.4 MAD 866 HCA Standardized CCP

4.17.5 MAD 902 CARA DUR Member Notification Form

4.17.1. Health Risk Assessment

TURQUOISECARE

Health Care Authority (HCA)
Health Risk Assessment (HRA)
CNA Required for Items in BLUE*

Demographic Information			
Member's Name (First, Middle, Last)	**Date of Birth**	**Medicaid ID**	**Assessment Date**

Race/Ethnicity	
☐Asian or Pacific Islander ☐Black or African American ☐Hispanic or Latino ☐White or Caucasian non-Hispanic ☐Multiracial or biracial ☐A race/ethnicity not listed ☐Native American or Alaskan Native Tribal Affiliation if applicable:	
Has the Member given permission for another person to complete this form? ☐Yes ☐No	**Name of person completing/assisting with the completion of this assessment and their relationship to Member** **(the HRA must be completed by the guardian for Members under the age of 14)**
Member's Address **Street:** **City:** **State/Zip:**	**Member's Telephone** **Cell:** **Home:** **Other:**

Email Address	**Preferred Method of Contact**	
	☐Voice ☐Text ☐Mail ☐Email	
Name of Emergency Contact	**Phone**	**Relation to Member**

Assessment Method
☐Telephonic ☐In-person ☐Other (describe):
Assessment Type
☐Initial assessment ☐Change in health status

	Question	Response
1.	Does the Member have a language need other than English? Do they need translation services?	☐Yes ☐No ☐Yes ☐No If yes, describe
2.	Does the Member have any special preferences we should be aware of?	☐Cultural preference: if yes, describe ☐Hearing Impairment: if yes, describe ☐Literacy: if yes, describe ☐Religion/spiritual needs or preferences: if yes, describe ☐Visual Impairment: if yes, describe ☐None ☐Other: if yes, describe
3.	What is the Member's main health concern right now?	
4.	Does the Member have any current or past physical and/or behavioral health conditions or diagnoses?	☐Behavioral health diagnosis (CNA required*) ☐Substance Use Disorder (SUD) (CNA required*) ☐Comorbid conditions (CNA required*) If yes, describe: ☐Residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (CNA required*) ☐Transplant patient (CNA required*) ☐Medically Fragile Waiver Program (CNA required*) ☐Other Waiver Program (CNA required*) ☐Medically Frail (CNA required*) ☐Traumatic Brain Injury/Acquired Brain Injury

		(TBI/ABI) (CNA required*) ☐Dementia/cognitive deficits (CNA required*) ☐Other acute or terminal disease (CNA required*) If yes, describe: ☐Other chronic condition (CNA required*) ☐None
5.	What sex was the Member assigned at birth, on their original birth certificate?	☐ Male ☐ Female ☐ X or intersex ☐ Decline/prefer not to answer
6.	*For individuals over 10 years of age:* What is the Member's current gender?	☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Non-binary ☐ Other: if yes, describe ☐ Decline/prefer not to answer ☐N/A *We ask this for reporting only. Your response will not have an effect on your benefits.*
7.	*For individuals over 10 years of age:* What is the Member's Sexual Identity?	☐ Gay or lesbian ☐ Straight, that is not gay or lesbian ☐ Bisexual ☐ Other: if yes, describe ☐ Decline/prefer not to answer ☐N/A *We ask this for reporting only. Your response will not have an effect on your benefits.*
8.	*For individuals over 10 years of age:* Is the Member pregnant?	☐Yes ☐No ☐N/A (if yes, CNA required*)
9.	*Is someone in the home eligible for Medicaid Home Visiting (MHV)? (Individuals in the Perinatal/Postpartum population and those with children up to five (5) years of age in the home.)* You qualify for Medicaid Home Visiting which is a no cost benefit available through your health plan. One of our Medicaid Home Visiting providers will be reaching out to you with more information. *For individuals requesting additional information.* Medicaid Home Visiting is a program that can give you tips to help your baby sleep safely, breastfeeding and nutrition support, finding childcare, preparing for school and more.	☐Yes ☐No
10.	*For individuals over 10 years of age:* Does the Member currently use tobacco and/or nicotine products?	☐Yes ☐No ☐N/A ☐Yes ☐No ☐N/A

	If yes, are they interested in receiving information on or participating in a tobacco cessation program? Does the Member have a history of using tobacco and/or nicotine products?	☐Yes ☐No ☐N/A
11.	What are the Member's most significant needs today?	
12.	Within the past 12 months, has the Member worried that they would run out of food or has the food the Member bought run out and the Member did not have money to get more?	☐Yes ☐No ☐N/A (if yes, refer for assistance)
13.	Does the Member have reliable transportation?	☐Yes ☐No ☐N/A (if no, refer for assistance)
14.	Does the Member need help finding a physical or behavioral healthcare provider?	☐Yes ☐No (if yes, refer to Member services)
15.	Has the Member visited the Emergency Room in the past 12 months? If yes, how many visits?	☐Yes ☐No ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 or more (if 4 or more, CNA required*)
16.	Has the Member stayed overnight in the hospital in the past 6 months? If yes, was the Member readmitted within 30 days of discharge?	☐Yes ☐No ☐Yes ☐No (if yes, CNA required*)
17.	How many medications is the Member currently taking?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more (if 6 or more, CNA required*)
18.	Is the Member in any of the following situations?	☐Justice involved ☐Children, Youth, and Families Department (CYFD) custody ☐Working with the Department of Health on a Plan of Care for the Comprehensive Addiction and Recovery Act (CARA) (if yes to any, CNA required*)
19.	What is the Member's current living situation?	☐Living alone ☐Living with family/spouse ☐Living with others unrelated ☐Homeless (CNA required*) ☐Living in shelter (CNA required*) ☐Living in group home ☐Lives in out of state facility (CNA required*) ☐Dependent child in out of home placement (CNA req.*) ☐Living in a nursing facility ☐Living in assisted living facility ☐Other: if yes, describe
20.	Does the Member need assistance with 2 or more of the following?	☐Yes ☐No (if yes, CNA required*) ☐Bathing ☐Dressing ☐Grooming ☐Toileting ☐Transfer ☐Bowel/bladder ☐Eating

		☐Mobility assistance ☐Meal preparation ☐Daily medication ☐Light housekeeping ☐Other: _____
21.	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. Does the Member have a living will or an advance directive in place? Could I send the Member more information?	☐Living will ☐Advance directive (for medical care) ☐Advance directive (for psychiatric care) ☐No living will or advance directive in place ☐Declined discussion ☐Requested further information
22.	Guidelines for Assessor explanation of Care Coordination: • A care coordinator is your main point of contact for information about services covered by [MCO name]. • These services include medications, doctor's appointments, physical therapy, medical equipment, hospital visits, vision and dental services and transportation to medical appointments. • Your care coordinator can help you find out if you qualify for Community Benefits. These benefits might include someone coming to your home to help you prepare meals or make home repairs that you need to stay safe. • Your care coordinator will help you find extra care and services from providers or community programs that are not covered by [MCO name]. • Your care coordinator will work with you and those who care for you to create a care plan. A care plan can help you meet your health goals. • There are two types of Care Coordination – Level 1 and Level 2. Level 1 is for people who need assistance with some of their health needs. Level 2 is for people with higher needs. • Your care coordinator will visit you in-person to do a Comprehensive Needs Assessment, or CNA. • The CNA will help find out what services you can receive. • Your care coordinator will check in with you by telephone as needed. • Your care coordinator will visit you in your home at least once a year. • You can ask for a higher level of Care Coordination at any time. • Native American Members have the right to request a Native American care coordinator.	
23.	Is the Member interested in receiving Care Coordination Services?	☐Yes ☐No (If yes, CNA required*)
24.	*For the Assessor: Inform the Member about specific next steps, such as scheduling the CNA, transferring the Member to Member Services, or supplying contact information for Income Support Division (ISD) for assistance with any issues that were discussed during the HRA.*	

4.17.2. MAD 601: Turquoise Care CNA Exception Request

HEALTH CARE AUTHORITY

Health Care Authority (HCA)
Comprehensive Needs Assessment (CNA)
Exception Request

Member Information	
Member's Name (First, Middle, Last)	**Medicaid ID**
Request Date	**Proposed Assessment Date**
Date of last *In-Person In-Home* CNA	**Does the Member have NFLOC?**

Requestor Information		
Name	**Title**	
Email Address		**Phone Number**

Member Diagnoses

Reason for Request

Proposed Alternate Location
Name of location: **Street address:** **City:** **State/Zip:** **Phone:**

Notes/Plan for Monitoring Home Environment

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4.17.3 MAD 869: Care Coordination Declination Form

Health Care Authority (HCA)
Care Coordination Declination

Member's Name (First, Middle, Last)	**Medicaid ID**

Care Coordination Supports

You told us that you did not want Care Coordination support. You have the right to decline this Turquoise Care support that is available at no cost to you. We want to make sure that you know what Care Coordination does and how it helps you.
Your Comprehensive Needs Assessment (CNA) helps decide which level of Care Coordination would be best for you. A care coordinator can help you manage your health and learn how to work with your providers to reach your health goals. A care coordinator is assigned to help you if level 1 or level 2 care coordination would best fit your needs.
If you are identified for Care Coordination, a care coordinator comes to your home and does an in-depth assessment. This assessment helps us know what healthcare services and supports are best for your needs.

Community Benefit Services

You may be able to get Community Benefits if you have certain long-term care needs. For example, if you need help with bathing, dressing, or moving around, you may qualify for these benefits. You must have an assessment done in your home by a care coordinator to get long-term care services. The assessment will tell us what your needs are, and which services may help support you in your home and the community, while safely meeting your healthcare needs. These long-term care services and supports are provided in your home or community. Your care coordinator will talk with you about your options if you qualify for Community Benefit services.

Agency-Based Community Benefit (ABCB) long-term care services covered by Turquoise Care include:

- Adult day health
- Assisted living
- Behavior support consultation
- Community transition services
- Emergency response services
- Employment supports
- Environmental modifications
- Home health aide
- Nursing respite services
- Nutritional counseling
- Personal care services (21 and older)*
- Private duty nursing (21 and older)*
- Respite services
- Skilled maintenance therapies*
  - Occupational Therapy (21 and older)
  - Physical Therapy (21 and older)
  - Speech Therapy (21 and older)

Self-Directed Community Benefit (SDCB)

You can choose to self-direct your care if you qualify for long-term care services and if you have been getting Agency-Based Community Benefit services for 120 calendar days. This means that you can select, hire, fire, and train your long-term Community Benefit care providers. You must also manage a budget and care plan for your long-term care services. You can direct your own SDCB services. Your care coordinator can explain your options and give you more information to help you decide if this is the right option for you. SDCB services covered by Turquoise Care include:

- Behavior support consultation
- Customized community supports
- Emergency response services
- Employment supports
- Environmental modifications
- Home health aide
- Nutritional counseling
- Private duty nursing (21 and older)*
- Related goods
- Respite
- Self-Directed Personal Care (21 and older)*
- Skilled maintenance therapies (21 and older*)
- Specialized therapies
- Start-up good and services
- Transportation (non-medical)

*Members under age 21 may get these services, as medically necessary, through their general Medicaid benefit.

I would like to decline Care Coordination Supports.
Member Name
Signature
Member Representative Name
Signature
Date

More Information
If, at a later date, you are interested in Care Coordination or need these supports or services, please contact [MCO] Care Coordination at [MCO Care Coordination Unit phone], or toll-free at [MCO Care Coordination Unit phone] and a care coordination representative will be happy to assist you.

Please return a signed copy of this form to:
[MCO address]

4.17.4 MAD 866 HCA Standardized CCP

TURQUOISECARE

Health Care Authority (HCA)
Comprehensive Care Plan (CCP)

Demographic Information			
Member's Name (First, Middle, Last)		**Date of Birth**	**Medicaid ID**
Name of Emergency Contact	**Phone**	**Relation to Member**	
Most Recent CNA Completion Date	**CCP Start Date**		
Medicaid Eligibility Renewal Date	**Preferred Method of Contact**		
	☐Voice ☐Text ☐Mail ☐Email		

Interdisciplinary Care Team (ICT) Information (Power of Attorney, parent, spouse, partner, providers, natural supports etc. – if applicable)		
Care Coordinator	**Phone**	**Email**
Name/Title	**Phone**	**Email (if applicable)**
Name/Title	**Phone**	**Email (if applicable)**
Name/Title	**Phone**	**Email (if applicable)**
Add rows for additional ICT participants		

Services that will be authorized by the MCO Including amount, frequency, duration and scope (tasks and functions to be performed) of each service to be provided.

Physical Health (PH) and Behavioral Health (BH) Conditions/Diagnoses Conditions, needs and functional status (i.e., areas of functional deficit); relevant information regarding the Member's PH and BH condition(s), including treatment that is needed by a Provider, caregiver or the care coordinator to ensure appropriate delivery of services or coordination of care.

Medications Including names, dosages, frequency, and discontinued medications

Backup Plan

I will talk with backup paid or unpaid caregivers about when they are available and my care needs before a situation comes up.
I will call one of the people listed below if my scheduled paid or unpaid caregiver does not show up at his/her scheduled time (examples: provider, friends, family, former workers, church members, other volunteers).

Name	Phone	Address	Relationship
Name	**Phone**	**Address**	**Relationship**

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Name	Phone	Address	Relationship
Add rows for additional contacts			
This is my plan in case my caregiver(s) don't show up and I can't reach one of the people listed above:			

Disaster Preparedness Plan

I will make and post a list of emergency contacts that my providers can easily find in the event of an unsafe or harmful situation. (Example: who to call for help in an emergency, or for help with decisions).

Name	Phone	Will be able to help with
Name	**Phone**	**Will be able to help with**
Name	**Phone**	**Will be able to help with**
Add rows for additional contacts		

These are my plans for a natural disaster, emergency preparedness, and/or evacuation plan. This includes the care of service animals or pets.

I understand I may only get my critical needs met in an emergency. Below is an up-to-date list of the tasks that are essential to my health and welfare:

☐Review needed items to take: (check all that apply)
☐Medication/drugs
☐Oxygen tank/concentrator
☐Nebulizer and attachments
☐Wound care supplies
☐Catheters/supplies
☐Feeding tube supplies
☐Identification (ID) cards and valuable papers
☐Special food
☐Clothing
☐Purse/wallet
☐Medical summary
☐Names/contact information of providers
☐Other:

Fill out appropriately to coordinate services

☐DME needs/provider:
☐Transportation needs/company:
☐I can get my medication drugs at:
☐Home health care agency:
☐Care of service animals or pets:
☐Have a list of emergency contacts (including my care coordinator)
☐Discussed with my care coordinator ways to stay safe in case of a fire, flood, or any other natural disaster.

*If I believe I am at risk of harm from abuse, neglect, or being taken advantage of, I know that I should call **Adult Protective Services at 1-866-654-3219. Child Protective Services at 1-855-333-7233.**
*If I believe I am experiencing an emotional crisis or having thoughts of hurting myself or others, I know that I should call the **New Mexico Crisis and Access Line at 1-855-NMCRISIS (662-7474).**

Other Services that will be Provided to the Member Any non-covered services including services provided by other community resources, including social support services, and assistance needed in order to ensure the Member's health, safety and welfare, and as applicable, to delay or prevent the need for more restrictive institutional placement, as reported by the Member.
☐N/A

Information About Services Provided by Medicare Payers, Medicare Advantage Plans and Medicare Providers To coordinate services for Members who are also Dual Eligible, as reported by the Member
Information/assistance needed/provided: ☐No needs identified ☐N/A

Frequency of Planned Care Coordinator Contacts Shall include consideration of the Member's individualized needs and circumstances and which shall meet minimum required contacts (additional care coordinator contacts shall be provided as needed).
☐**CCL1 Contact Guidelines:** 1 CNA per year, 1 bi-annual in-person visit, quarterly telephonic touchpoints. *Additional touchpoints may be conducted as needed.*
☐**CCL2 Contact Guidelines:** 2 CNAs per year, 1 bi-annual in-person visit, quarterly telephonic touchpoints. *Additional touchpoints may be conducted as needed.*
☐**Other** contact schedule requested by Member (list):

Member's Choice (if applicable)
☐Agency Based Community Benefit (CB) ☐Self-Directed CB ☐Nursing Facility

Member's Choice of Community Benefit Settings and Providers (if applicable)
List facilities/settings/providers offered to member and identify and document member choice:

Opportunities, Goals, Interventions and Desired Health, Functional and Quality of Life Outcomes for the Member
Opportunity: ☐**High Priority** ☐**Medium Priority** ☐**Low Priority**
☐ **Member has an Allocation Tool for Community Benefit Personal Care Services (PCS)** **{Member name}'s Allocation Tool has been included in their member file.**
Strengths:
Barriers:
☐**Member deferred discussion** **Reason deferred (if stated):** ☐**Member declined discussion** **Reason declined (if stated):**
Goal:
Action I will take to achieve this goal:

Begin Date:	Target End Date:	Date Goal Accomplished:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Add rows for additional opportunities/goals		
Action my care coordinator will take to help me achieve this goal:		
Begin Date:	Target End Date:	Date Goal Accomplished:

Opportunity: ☐**High Priority** ☐**Medium Priority** ☐**Low Priority**
Strengths:
Barriers:
☐**Member deferred discussion** **Reason deferred (if stated):** ☐**Member declined discussion** **Reason declined (if stated):**
Goal:
Action I will take to achieve this goal:

Begin Date:	Target End Date:	Date Goal Accomplished:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Progress Update:		Date:
Add rows for additional opportunities/goals		
Action my care coordinator will take to help me achieve this goal:		
Begin Date:	Target End Date:	Date Goal Accomplished:
Add rows for actions care coordinators will take as needed.		

☐**Member has Community Benefits**
Describe MCO plan to ensure member has opportunities for Community Integration.

☐**Member has a Care Plan developed by the facility where they reside or receive services**
{Member name}'s Facility Care Plan has been included in their member file.

4.17.5 MAD 902 CARA DUR Member Notification Form









CARA DUR Member Notification Form

(DUR: Difficult to Engage, Unable to be Reached, Refused Care Coordination)

MCOs: Please email this document to CARA Staff: DOH-Cara@doh.nm.gov
Efax: 505-990-5874

Date: _____

Care Coordination Level:
☐Difficult To Engage (DTE)
☐Unable to be Reached (UTR)
☐Refused Care Coordination (RCC)

SCI Report:
Was an SCI Report completed? ☐Yes ☐No

MCO Reporter
Name
MCO
Phone Number
Email

CARA Member Information
Name
Medicaid ID
Member Date of Birth

Parent/Guardian Contact Information:	
Name	
Address:	
Phone	Email

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4.17.6 MAD 867 HCA Comprehensive Needs Assessment

TURQUOISECARE

Health Care Authority (HCA)
Comprehensive Needs Assessment (CNA)

Demographic Information			
Member's Name (First, Middle, Last)	**Date of Birth**	**Medicaid ID**	**Assessment Date(s)**

Race/Ethnicity
☐Asian or Pacific Islander ☐Black or African American ☐Hispanic or Latino
☐White or Caucasian non-Hispanic ☐Multiracial or biracial ☐A race/ethnicity not listed
☐Native American or Alaskan Native Tribal Affiliation if applicable:

What sex was the Member assigned at birth?
☐Male ☐Female ☐X or intersex ☐ Decline/prefer not to answer

What is the Member's current gender?
☐Male ☐Female ☐Transgender Man ☐Transgender Woman ☐Non-binary ☐Other
☐ Decline/prefer not to answer

What is the Member's sexual identity?
☐Gay or lesbian ☐Straight, that is not gay or lesbian ☐Bisexual ☐Other
☐ Decline/prefer not to answer

Member's Address	**Member's Telephone**
Street: **City:** **State/Zip:**	**Cell:** **Home:** **Other:**
Email Address	**Preferred Method of Contact** ☐Voice ☐Text ☐Mail ☐Email

Name of Emergency Contact	**Phone**	**Relation to Member**

MCO Enrollment Date	**Category of Eligibility (COE)**
Medicaid Eligibility Begin date	**Medicaid Eligibility Renewal Date**

Is the Member Justice-Involved?	**Is the Member a Comprehensive Addiction and Recovery Act (CARA) individual?**
☐Yes ☐No If yes, specify	☐Yes ☐No

Is the Member Children Youth and Families Department (CYFD)
☐Yes ☐No
If yes, specify

Is the Member a Child In State Custody (CISC)?
☐Yes ☐No
If yes, specify

Does the Member have any other insurance in addition to New Mexico Medicaid?	**Is the Member on a Waiver?**
☐Yes ☐No If yes, specify	☐Yes ☐No If yes, clarify type of Waiver

Assessment Method
☐In-person in-home ☐In-person (alternate location exception approved)
☐Telephonic (exception approved) ☐Video (exception approved)

Assessment Type (check all that apply)
☐Initial ☐Annual ☐Semi-Annual ☐Change in Condition ☐Treat First

Name/Relation of Person(s) Completing CNA if Other than Identified Member

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Name/Relation of Person(s) Participating in the CNA in addition to the Member, if applicable

Authorized Representative Information **(Power of Attorney, Parent, Spouse, Partner, etc. – if applicable)**		
Name/Title	**Phone**	**Email**
Who is the decision maker?	**Was documentation submitted?**	**Type of documentation submitted**
	☐Yes ☐No	
Do we have permission to contact the representative without the Member present?		
☐Yes ☐No		

Introduction		
Number	**Question**	**Response**
1.	Before beginning, is the Member experiencing an emergency right now? For example, chest pain, stroke symptoms, or thoughts of hurting themselves or someone else?	☐Yes ☐No STOP AND CALL 911 IF THERE IS IMMINENT RISK.
2.	Does the Member meet requirements for a Community Benefits Service Questionnaire (CBSQ)/Community Benefits Member Agreement (CBMA)?	☐Yes ☐No If yes, complete CBSQ/CBMA
3.	What are the Member's most significant needs today?	
4.	Does the Member have a language need other than English? Does the Member need translation services?	☐Yes ☐No ☐Yes ☐No If yes, describe
5.	Does the Member have any special preferences we should be aware of?	☐Cultural preference If yes, describe ☐Literacy If yes, describe ☐Religion/spiritual needs or preferences If yes, describe ☐None ☐Other If yes, describe
6.	How many times has the Member been seen in the Emergency Department in the last 12 months?	☐0 ☐1 ☐2 ☐3 ☐4 or more ☐unknown Describe, if appropriate
7.	Does the Member need information on alternatives to the Emergency Department?	☐Yes ☐No
8.	How many times has the Member been in the hospital in the last 6 months?	☐0 ☐1 ☐2 ☐3 or more Describe, if appropriate
9.	Has the Member been approved for or are they waiting for any type of transplant?	☐Yes ☐No If yes, specify

Vision/Hearing/Dental		
Number	**Question**	**Response**
10.	Does the Member currently have any vision issues?	☐Yes ☐No If yes, describe
11.	When was the last time the Member had their vision tested by an eye care professional?	

12.	Does the Member need any assistance obtaining an eye care professional appointment?	☐Yes ☐No
13.	Does the Member have any hearing issues?	☐Yes ☐No If yes, describe
14.	When was the last time the Member had their hearing tested by a hearing professional?	
15.	Does the Member need any assistance obtaining an appointment with a hearing specialist?	☐Yes ☐No If yes, describe
16.	When was the last time the Member had a dental visit?	
17.	Does the Member need any assistance obtaining a dental appointment?	☐Yes ☐No If yes, describe

Pregnancy (if applicable)		
Number	**Question**	**Response**
18.	Is the Member currently pregnant?	☐Yes ☐No If yes, have they had perinatal care? ☐Yes ☐No If yes, what is their due date? If yes, have they been told their pregnancy is high risk? ☐Yes ☐No If yes, do they need assistance finding a Maternal Health Care Provider or scheduling an appointment? ☐Yes ☐No If no, have they been pregnant within the last 12 months? ☐Yes ☐No If yes, have they experienced postpartum depression? ☐Yes ☐No
19.	How many times has the Member been pregnant (including current pregnancy if pregnant)? How many viable births has the Member had?	
20.	Does the Member have a history of mutiple births?	☐ Yes ☐No ☐ Unknown
21.	Has the Member ever had a C-section?	☐ Yes ☐No ☐ Unknown
22.	Did the Member ever experience complications during a previous pregnancy or delivery?	☐Yes ☐No ☐N/A If yes, specify
23.	Is the Member interested in being referred to a Medicaid Home Visiting program?	☐Yes ☐No ☐N/A if yes, enter Home Visiting Provider Member was referred to:

Physical Health (PH) Needs		
Number	**Question**	**Response**
24.	How would the Member describe their overall health compared to a year ago?	☐Excellent ☐Good

		☐Fair ☐Poor
25.	What physical health conditions/diagnoses does the Member have?	☐Diagnosis ☐Self-Reported
26.	What is the Member's height? What is the Member's weight?	
27.	Does the Member have any known allergies not related to medications?	☐Yes ☐No If yes, specify to what and the type of reaction
28.	Has the Member seen a healthcare provider in the last 12 months (to include any preventative health screenings, vaccinations)?	☐Yes ☐No If yes, specify
29.	Does the Member need assistance obtaining an appointment with a Primary Care Provider (PCP) or a healthcare provider?	☐Yes ☐No
30.	In the last 12 months, has the Member (child) had a well-child visit?	☐Yes ☐No If yes, enter date
31.	When was the Member's last mamogram (if applicable)?	
32.	When was the Member's last pap smear (if applicable)?	
33.	Has the Member had a colorectal screening (if applicable)?	☐Yes ☐No If yes, specify If no, specify
34.	What surgeries, procedures, treatments has the Member had in the past?	
35.	Does the Member have any medical appointments, medical tests, surgeries, or other health services planned for the next 3-6 months?	☐Yes ☐No If yes, specify
36.	Does the Member need assistance in scheduling appointments or procedures?	☐Yes ☐No
37.	Does the Member use or need Durable Medical Equipment (DME)?	☐Yes ☐No If yes, specify
38.	Does the Member need assistance obtaining needed DME?	☐Yes ☐No If yes, specify
39.	Does the Member have any neurological diagnoses such as dementia, epilepsy, or a Traumatic Brain Injury (TBI) or Aquired Brain Injury (ABI)?	☐Yes ☐No If yes, specify diagnoses and onset date
40.	Does the Member smoke, vape, or chew tobacco?	☐Yes ☐No If yes, are they interested in receiving information on or participating in a tobacco cessation program? ☐Yes ☐No

Medication		
41.	Does the Member take any prescribed or over the counter medications?	☐Yes ☐No If yes, specify: ☐1☐2☐3☐4☐5 ☐6 or more
42.	Is the Member able to obtain all their needed medications?	☐Yes ☐No If no, specify
43.	Does the Member have any prescribed or over the counter medications that they are no longer taking?	☐Yes ☐No If yes, specify

44.	Does the Member have any known allergies to medications?	☐Yes ☐No If yes, specify to which medication and the type of reaction
45.	Does the Member take medications that cannot be stopped or would risk their life if not taken?	☐Yes ☐No If yes, specify

Behavioral Health (BH) Needs		
46.	What behavioral health conditions/diagnoses does the Member have?	☐Diagnosis ☐Self-Reported ☐ NA
47.	In the past 12 months has the Member had any BH emergency/inpatient/residential admisssions?	☐Yes ☐No If yes, specify
48.	When was the Member's most recent visit to a BH provider?	
49.	Does the Member need any asssitance obtaining a BH provider or appointment?	☐Yes If yes, specify
50.	Does the Member have a good overall understanding of their BH condition(s)?	☐Yes ☐No ☐Unsure
51.	Does the Member have any current or past alcohol or substance use issues?	☐Yes ☐No If yes, specify

PHQ-2/PHQ-9					
In the past two weeks, how often have you been bothered by any of the following problems?					
		Not At All	**Several Days**	**More Than Half The Days**	**Nearly Every Day**
52.	Little interest of pleasure in doing things	0	1	2	3
53.	Feeling down, depressed, or hopeless	0	1	2	3
	Column Totals (questions 52-53)				
	Total PHQ-2 Score (add column totals)				
If applicable, continue with questions 54-61:					
54.	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
55.	Feeling tired or having little energy	0	1	2	3
56.	Poor appetite or overeating	0	1	2	3
57.	Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
58.	Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3
59.	Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around alot more than usual	0	1	2	3
60.	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
	Column Totals (questions 52-60)				
	Total PHQ-9 Score (add column totals)				
61.	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult			

CAGE		
62.	Have you ever felt you should cut down on your drinking?	☐Yes (1) ☐No (0) If yes, specify
63.	Have people annoyed you by criticizing your drinking?	☐Yes (1) ☐No (0) If yes, specify
64.	Have you ever felt bad or guilty about your drinking?	☐Yes (1) ☐No (0) If yes, specify
65.	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	☐Yes (1) ☐No (0) If yes, specify
	Total Score	

Health Related Social Needs (HRSN)		
66.	Does the Member have any indicators of housing insecurity?	☐Yes ☐No If yes, specify
67.	Does the Member live alone or with others?	☐Alone ☐With others If with others, specify
68.	Does the Member feel physically and emotionally safe where they are living?	☐Yes ☐No If no, specify
69.	Does the Member have urgent needs (example: Member does not have a place to sleep tonight, no food, or has fear of harm in the home)?	☐Yes ☐No If yes, specify
70.	Would the Member like a referral to our Housing Specialist?	☐Yes ☐No
71.	Does anyone in the Member's household receive Community Benefit (CB) services?	☐Yes ☐No If yes, specify Type of services received MCO services are received from
72.	Does the Member have any natural supports such as an unpaid family/friend caregiver?	☐Yes ☐No If yes, list name(s) and contact information If yes, does the Member feel the time spent with the natural support meets their needs? ☐Yes ☐No If no, explain
73.	Does the Member have a paid caregiver?	☐Yes ☐No If yes, list name(s) and contact information If yes, specify hours/days per week
74.	Does the Member have sufficient child care?	☐Yes ☐No ☐N/A
75.	Within the past 12 months, has the Member worried that they would run out of food or has the food the Member bought run out and the Member did not have money to get more?	☐Yes ☐No
76.	How does the Member describe their current work situation/employment status?	
77.	What is the Member's primary source of income?	
78.	Is the Member able to manage financial matters independently?	☐Yes ☐No If no, specify
79.	Does the Member have any legal issues?	☐Yes ☐No If yes, specify

80.	Does the Member have reliable transportation?	☐Yes ☐No If no, specify
81.	Does the Member need any assistance in obtaining or referrals for: • Housing • Caregiver support • Childcare support • Food • Employment • Transportation • Financial/Legal • Utilities	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No

Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs)		
82.	Does the Member need assistance with any of the following ADLs?	Bathing ☐Yes ☐No If yes, describe Dressing ☐Yes ☐No If yes, describe Grooming ☐Yes ☐No If yes, describe Bowel/bladder ☐Yes ☐No If yes, describe Toileting ☐Yes ☐No If yes, describe Eating ☐Yes ☐No If yes, describe Mobility Assistance ☐Yes ☐No If yes, describe Transfer ☐Yes ☐No If yes, describe Meal preparation and assistance ☐Yes ☐No If yes, describe Daily medication ☐Yes ☐No If yes, describe
83.	Does the Member need assistance with any of the following IADLs?	Support Services ☐Yes ☐No If yes, describe Minor Maintenance of DME ☐Yes ☐No If yes, describe Light Housekeeping ☐Yes ☐No If yes, describe Finances ☐Yes ☐No If yes, describe
84.	Does the Member have any indications of fall risk?	☐Yes ☐No If yes, specify
85.	Does the Member need to be evaluated for a Nursing Facilty Level of Care (NF LOC) or do they intend to access Long Term Services and Supports (LTSS)?	☐Yes ☐No

Summary		
86.	What is the Member's main health goal or outcome they want to achieve?	
87.	Provide a summary of the Member's Physical Health (PH), including objective observations related to the Member's physical health.	
88.	Provide a summary of the Member's Behavioral Health (BH), including objective observations related to the Member's behavior.	
89.	Provide overall, objective observations of: • Safety of the Member's home environment • Member's vision, hearing, language • Member's caregiver resources or needs, including a summary of objective observations related to the Member's functional needs (example: no mobility limitations observed, unsteady gait observed, if Member was able to operate assistive devices/DME, indicate Member's range of motion, were they able to sign paperwork/eat/drink, any observations that may impact the Member's ability and inability to perform ADLs/IADLs) • Member's HRSN needs • Any additional observations	
90.	What community/provider referrals were needed and/or provided to the Member?	
91.	What assistance was needed and/or provided to the Member in scheduling appointments?	
92.	Does the Member have an advance directive?	☐Yes ☐No If no, would they like more information? ☐Yes ☐No

Care Coordination Engagement		
93.	Per Comprehensive Needs Assessment, Member meets criteria for (may check more than one box):	☐CCL1 (at a minimum) ☐Members who meet NF LOC or are receiving Long Term Services and Supports (LTSS)* ☐Perinatal/Postpartum Members* ☐ Member engaged in Medicaid Home Visiting (MHV) (1 year postpartum) ☐Waiver Member* ☐Member with three or more complaints, grievances, or appeals related to the Member's experience with the service delivery system ☐Behavioral Health diagnosis (non-SUD/SMI/SED) ☐Frequent emergency room use with four or more annual individual patient visits* ☐Has an acute disease, as defined by the MCO ☐ Justice Involved (13 months post release)* ☐Member has housing insecurity

		☐Readmitted to the hospital within thirty (30) Calendar Days of discharge ☐Has Dementia or mild or more significant cognitive deficits requiring prompting or cueing* ☐Has poly-pharmaceutical use, defined as simultaneous use of six (6) or more medications from different drug classes and/or simultaneous use of three (3) or more medications from the same drug class ☐Other (specify) ☐CCL2 ☐Is a dependent child in an out-of-home placement* ☐High Cost Member ☐Member with Substance Use Disorder (SUD) ☐Member with Serious Emotional disturbance (SED) ☐Member with Serious Mental Illness (SMI) ☐Justice-Involved Member who have been incarcerated within the last year* ☐Members who are homeless* ☐Member has a TBI ☐Children In State Custody (CISC) Member* ☐CARA Member* ☐Member is in an out-of-state Medical placement* ☐Medically Fragile Member* ☐Is a transplant recipient* ☐Is residing in an ICF/IID* ☐Multi-comorbidity ☐Terminal illness* ☐Medically Frail ☐Other (specify) *These Members may not be leveled down. Please refer to TC Care Coordination Leveling Guide
At this time, the care coordinator will explain Care Coordination to the Member, including the number of touch points for the two levels and what a care coordinator can assist with.		
94.	Is the Member interested in Care Coordination?	☐Yes ☐No
95.	What is the Member's assigned Care Coordination Level?	☐CCL0 ☐CCL1 ☐CCL2 ☐Initial Not Otherwise Medicaid Eligible (NOME) If the Member's assigned Care Coordination Level does not match criteria noted in Q.93, please specify the reason:
96.	If the Member refused Care Coordination:	☐Yes ☐No ☐N/A

	Was the HCA approved Care Coordination Declination Form explained and signed? What was the reason for refusal?	If no, explain Specify
97.	Summarize the care coordinator's conclusions about the Member's eligiblity and access to community resources and the next steps that will be taken by the care coordinator and the Member.	
At this time, the care coordinator will discuss the Comphensive Care Plan (CCP) and process for the CCP with the Member.		
98.	Were the CBSQ and CBMA completed?	☐Yes ☐No ☐N/A If no, explain
At this time, the care coordinator will explain Alternative Benefit Program (ABP) Exempt to the Member.		
99.	Does Member have a COE 100 ABP? Does Member want to be evaluated for ABP Exempt?	☐Yes ☐No ☐Yes ☐No ☐ABP ☐ABP Exempt ☐N/A
100.	Does the Member qualify for ABP Exempt?	☐Yes ☐No If yes, specify PH or BH exempt reason
101.	Has the care coordinator assessed the Member's living arrangement to ensure compliance with the HCBS settings rule?	☐Yes ☐No ☐N/A If no, explain
102.	Member was provided with information on all available services and benefits.	☐Yes ☐No If no, explain
103.	Describe the member's satisfaction with services and care.	
104.	Is the Member being assessed for Complex Case Management or considered for initial NFLOC?	☐Initial NFLOC ☐Complex Case Management ☐N/A

5. Transitions of Care

5.1. General Information

In managed care, HCA 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 entering or returning home from a foster care placement;
- Transition for Member(s) released from correctional institutions, including juvenile or adult prisons, jail or detention center facilities;
- Transition for Member(s) moving from an out-of-state placement to an in-state placement;
- Transition from ARTC or RTC to TFC, group home or foster care.
- 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
- Transition for Member(s) who are preparing to receive out-of-state treatment.

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;
- A recommendation from the Individualized Planning Meeting Plan for a child or youth in CYFD PS custody or CYFD JJS;
- 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 HCA's standardized TOC Plan (See Appendix 5.14.1).The Transition of Care Plan must be clearly labeled for MCO tracking and HCA 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.

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.

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 HCA 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 and CYFD secure facilities, RTCs, psychiatric hospitals, behavioral health facilities) to address at a minimum:

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

The MCO shall notify the assigned CYFD Permanency Planning Worker (PPW) for protective services (PS) involved children and youth and Juvenile Probation Officer (JPO) for juvenile justice -involved youth, and Community Behavioral Health Clinician (CBHC) within 30 Business Days prior to transition in care for CYFD -involved children/youth. Precipitous discharge from these placements is prohibited.

The MCO shall perform an in-home- assessment for Members who are transitioning from an inpatient hospital, and may be in need of Community Benefits, 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;
- 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 Authorized Representative 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.

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.

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 phaseout time periods for each of these individuals, and to maintain written policies, procedures, and documentation to address coverage transitions.

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 ongoing 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.

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 HCA 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;
  - Continuity of behavioral health services, if requested;

- Guardianship; and
- Transportation.

- Ensure Members and, when authorized, family Members, guardians and PCPs are part of the development and implementation of the transition plan. The MCO shall also ensure that the assigned CYFD Permanency Planning Worker (PPW) and/or youth transition specialist for Protective Services (PS) involved children and youth, Juvenile Probation Officer (JPO) or transition coordinator for juvenile justice involved youth, and Community Behavioral Health Clinician (CBHC) for CYFD involved children/youth are part of the development and implementation of the transition plan for CYFD involved children/youth.
- 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.

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.

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.

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.

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.

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, including but not limited to, the Member file, within 5 business days of CARA or CISC Member transitions and within 10 business days for all other Member transitions. Once the exiting MCO receives the termination on the daily enrollment roster from the State of New Mexico they will have an SLA of no more than 15 calendar days to provide all Transition of Care files to the receiving MCO's SFTP.
- 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 onsite 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.

5.12 Transitions of Care for Justice Involved Members

The MCO shall develop and implement policies and procedures for ensuring that Members released from incarceration or detention facilities transition successfully back into the community. At a minimum, MCOs must:

- Initiate the HCA MAD 900 JUST Health APHRA Transition of Care (TOC) assessment with the Member prior to Member's release or within three (3) business days of notification of Member's release.
- The Transition of Care Plan, within the MAD 900 JUST Health APHRA, shall remain in place for a minimum of sixty (60) calendar days from the Member's release or sixty (60) calendar days from notification of Member's release.
- Initiate a Comprehensive Needs Assessment (CNA), within thirty (30) business days of Member's release or within thirty (30) business days of notification of Member's release. The CNA may be completed over the course of four appointments but must be completed within 90 days of the Member's release or MCO notification of Member's release.
- Follow all contract requirements for ongoing Care Coordination including development of a Comprehensive Care Plan, utilizing information from the completed MAD 900 JUST Health APHRA and CNA, and required touchpoints pursuant to the Medicaid Managed Care Services Agreement 4.4.
- Contact the Member monthly for three (3) months after Member's release to ensure continuity of care has occurred and that the Member's needs, identified in the MAD 900 JUST Health APHRA, have been met.

5.13 Transitions of Care for Substance Exposed infants

The MCO shall develop and implement policies and procedures to ensure care coordinators assist in addressing the needs of pregnant mothers and fathers with opioid use disorders and their infants. Once the Member is referred to the MCO by DOH or a hospital, the MCO care coordinator will be responsible for assessing, referring, and coordinating support services identified in the Comprehensive Addiction and Recovery Act (CARA) Plan of Care (POC). MCO care coordinators are responsible for collaborating and coordinating care for the infant, affected mother/father and family and caregivers in accordance with the Children, Youth and Families Department (CYFD).

At a minimum, MCOs are responsible for:

- Providing annual training for Care Coordination staff on the Comprehensive Addiction and Recovery Act (CARA) Plan of Care (POC) to address the needs of both the pregnant women with opioid use disorders and their substance-exposed newborns. Training to include the difference between CYFD notification and CYFD referral or report;
- Coordinating care with the CYFD case worker, in cases where a child protective services case is determined necessary;
- Ensuring Care Coordination staff communicate and collaborate with hospital staff on implementation of the POC;
- Obtaining a copy of the POC from the hospital discharge planner;
- Ensuring MCO Care Coordination staff introduce support service providers identified in the POC to the infant and mothers including family and caregivers;
- Conducting a Health Risk Assessment (HRA) with the substance abuse-exposed infant inpatient whenever possible, and if not, within 24 hours after discharge from the hospital. ;
- Completing a Comprehensive Needs Assessment (CNA) in the Member's home within seven (7) days of discharge to determine if the Member(s) should be assigned to Care Coordination Level One (CCL1) or Care Coordination Level Two (CCL2); Following all contract requirements for ongoing Care Coordination for Member(s) leveled at CCL1 or CCL2, including development of a Comprehensive Care Plan (CCP) and required touchpoints pursuant to section 4.4 of the Medicaid Managed Care Services Agreement and sections 5.2 and 5.3 of the Managed Care Policy Manual; including but not limited to home visitation programs, early intervention services

and recovery supports. MCOs should refer to contract requirements detailed in sections 4.4.6 and 4.4.7 that include, but are not limited to, high risk pregnancy and co-morbid health conditions as CCL1 and medically complex and/or untreated substance abuse dependency as CCL2; and

- Notifying CYFD if the mother and/or family/caregiver(s) are Unable to be Reached, Difficult to Engage, Refuse Care Coordination.

5.14 Appendix

5.14.1 MAD 868 HCA Standardized TOC Assessment

TURQUOISECARE

Health Care Authority (HCA)
Transition of Care (TOC) Assessment/Plan

1. Demographic Information			
Member's Name (First, Middle, Last)		**Date of Birth**	**Medicaid ID**
Date of MCO Notification of Transition	**TOC Plan Start Date**	**Transition Date**	**TOC Plan Completion Date**

Member's Address Prior to Transition **Street:** **City:** **State/Zip:**	**Member's Telephone** **Cell:** **Home:** **Other:**
Email Address	**Preferred Method of Contact** ☐Voice ☐Text ☐Mail ☐Email

Name of Emergency Contact	**Phone**	**Relation to Member**
Medicaid Eligibility Begin date	**Medicaid Eligibility Renewal Date**	

The CISC PC contact information will only be completed/populated into the TOC plan provided for CISC Members.

For Children in State Custody (CISC) Members (if applicable):	
Permanency Coordinator (PC) Name	**PC Phone**

Transition Type:

☐ Nursing Facility (NF)
Higher to lower Level of Care (LOC):
- ☐Acute inpatient (IP)
- ☐Residential Treatment Center (RTC)
- ☐Social detoxification program
- ☐Treatment Foster Care (TFC)
- ☐Other (specify)

☐ Turning 21 (complete sections 1, 5, and 6 only)
☐ Substance exposed infants: 60 days prior to graduation from Comprehensive Addiction and Recovery Act (CARA) program (complete sections 1, 2, 5, and 7 only)
☐ CISC 066/086 Members (sections 1, 2, 5, and 8 only)
☐ Other (specify)

This section will only be completed/populated into the TOC plan provided for Members discharging from a facility.

2. Coordination with Discharge (D/C) Planning Team
If no needs are identified for a requirement, enter "none" in Needs column

Summary of contact attempts
(if d/c planning team was not reached, enter "None" in "Needs Identified by D/C Planning Team column)

	Requirement	Needs Identified by D/C Planning Team	Actions
1.	Need for Home and Community Based Services	☐None ☐Yes (if yes, describe)	

2.	Follow-up appointments	☐None ☐Yes (if yes, describe)	
3.	Therapies and treatments	☐None ☐Yes (if yes, describe)	
4.	Medications	☐None ☐Yes (if yes, describe)	
5.	Durable Medical Equipment (DME)	☐None ☐Yes (if yes, describe)	

This section will not be completed for Members Turning 21 and will only populate into the TOC plan provided to the Member if it is completed.

3. Transition of Care (TOC) Assessment/Plan **If no needs are identified for a requirement, enter "none" in Needs column**			
Requirement		**Needs**	**Actions**
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Community Benefits	☐None ☐Yes (if yes, describe)	
4.	Continuation of Medicaid eligibility	☐None ☐Yes (if yes, describe)	
5.	PH/BH providers	☐None ☐Yes (if yes, describe)	
6.	Community resource providers	☐None ☐Yes (if yes, describe)	
7.	Housing	☐None ☐Yes (if yes, describe)	
8.	Financial	☐None ☐Yes (if yes, describe)	
9.	Interpersonal skills	☐None ☐Yes (if yes, describe)	
10.	Safety	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided to the Member if they require a 3-Day Post-Discharge In-Home Assessment (Members transitioning from inpatient hospital or NF stay who may be in need of Community Benefits).

4. 3-Day Post-Discharge In-Home Assessment **If no needs are identified for a requirement, enter "none" in Needs column**			
Requirement		**Needs**	**Actions**
1.	Safety in the home environment	☐None ☐Yes (if yes, describe)	
2.	Physical Health Needs	☐None ☐Yes (if yes, describe)	
3.	Behavioral Health Needs	☐None ☐Yes (if yes, describe)	

4.	Housing Needs	☐None ☐Yes (if yes, describe)	
5.	Continuation of Medicaid Eligibility	☐None ☐Yes (if yes, describe)	
6.	Financial Needs	☐None ☐Yes (if yes, describe)	
7.	CNA **if one is not in place**	☐None ☐Yes (if yes, describe)	
8.	Community Benefit needs and services in place	☐None ☐Yes (if yes, describe)	

5. Monthly Follow-Up (for 3 months)

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. If the CCP is in place prior to the 3rd monthly follow-up, that assessment is not required to be conducted. If no needs are identified for a requirement, enter "none" in Additional Needs/Notes column. Additional rows may be added to accommodate further follow-up.

	Date	Additional Needs/Notes
1.		☐None ☐Yes (if yes, describe)
2.		☐None ☐Yes (if yes, describe)
3.		☐None ☐Yes (if yes, describe)

This section will only be completed/populated into the TOC plan provided for Members turning 21.

6. Transition for Members Turning 21

If no needs are identified for a requirement, enter "none" in Needs column

	Requirement	Needs	Actions
1.	Health condition management	☐None ☐Yes (if yes, describe)	
2.	Developmental and functional independence	☐None ☐Yes (if yes, describe)	
3.	Education	☐None ☐Yes (if yes, describe)	
4.	Social and emotional health	☐None ☐Yes (if yes, describe)	
5.	Continuity of BH services (if requested)	☐None ☐Yes (if yes, describe)	
6.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
7.	Transportation	☐None ☐Yes (if yes, describe)	
8.	EPSDT services and provider needs	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CARA Members.

7. Transition for Members Graduating from CARA **If no needs are identified for a requirement, enter "none" in Needs column**			
	Requirement	**Needs**	**Actions**
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	
8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	

This section will only be completed/populated into the TOC plan provided for CISC Members.

8. Transition for CISC 066/086 Members **If no needs are identified for a requirement, enter "none" in Needs column**			
	Requirement	**Needs**	**Actions**
1.	Physical Health (PH)	☐None ☐Yes (if yes, describe)	
2.	Behavioral Health (BH)	☐None ☐Yes (if yes, describe)	
3.	Well care visits	☐None ☐Yes (if yes, describe)	
4.	Developmental and functional milestones	☐None ☐Yes (if yes, describe)	
5.	CYFD involvement	☐None ☐Yes (if yes, describe)	
6.	Current placement and permanency plan	☐None ☐Yes (if yes, describe)	
7.	PH/BH providers	☐None ☐Yes (if yes, describe)	

8.	Education for parent/guardian	☐None ☐Yes (if yes, describe)	
9.	DME/service needs	☐None ☐Yes (if yes, describe)	
10.	Community resources	☐None ☐Yes (if yes, describe)	
11.	Guardianship (if applicable)	☐None ☐Yes (if yes, describe)	
12.	Transitioning to a new MCO (if applicable)	☐None ☐Yes (if yes, describe)	

6. Nursing Facilities (NFs)

6.1. General Information

This policy establishes guidelines for the MCOs regarding NFs. The NF LOC Criteria and instructions is posted on the HCA website at https://www.hca.nm.gov/providers/nursing-facility-level-of-care/.

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 or designated MCO email address.

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

Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability (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 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 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.

  - 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 readmission 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.

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:
    - LNF initial
    - LNF- Continued Stay
    - HNF- Initial
    - HNF- Continued Stay

- Medicaid Pending- Initial
- Medicaid Pending- Continued Stay
- NF Transfer
- LOC Change
- Discharge Status
- Re- Admission
- Re-Review
- Reconsideration
- Reserve Bed Days (PA Request)
- 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 copay 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).

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 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 will provide the NF with a written explanation of why a HNF request is downgraded to LNF, that includes applicable citations from the NF LOC Criteria and Instructions.

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

Short-term skilled stays:

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.

The updated NF LOC criteria published on 01/ 01/2019 includes General Eligibility Requirements under Section V. This section explains the minimum requirements for LOC and includes information on when the MCO should not assign a LOC, but rather issue a skilled nursing authorization.

Not appropriate for NF care: The Member's needs are too complex or inappropriate for NF, such that:

- The Member requires acute level of care for adequate diagnosis, monitoring and treatment or

requires inpatient based acute rehabilitation services.

- Members who reside in a NF long-term and have a clinical episode which requires hospitalization, should be evaluated for skilled nursing services once readmitted to the facility to determine if the Member requires acute therapy related to the hospitalization.
- Members who reside in a NF long-term and have a clinical episode which does not require hospitalization, but may indicate a change in LOC, should be evaluated for HNF.
- Members who do not reside in the NF but have been hospitalized and require inpatient based acute rehabilitation services should be evaluated for skilled nursing services.

6.5. Denied NF LOC Determinations

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 receipt of a completed packet, with the reason for denial as determined by the MCO. The requesting provider then has the opportunity to request a re-review and/or reconsideration of the MCO's decision per the timelines indicated in section 6.15. 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.
Providers who disagree with the initial review decision must request a re-review of the decision(s) before requesting a reconsideration. Please see section 6.15 for timelines and requirements.
If the NF LOC criteria are 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.

6.6 MCO NF LOC ASPEN Inquiries

The purpose of this section is to outline the process for MCOs to obtain additional information from HCA/MAD/Long-Term Services & Supports Bureau (LTSSB) related to NF LOC, ASPEN 112 Triggers for NF LOC, or other information that may be impacting the NF LOC status, such as:

- Receiving a Nursing Facility Packet from a facility requesting a Level of Care completion but no 112 Trigger from the ASPEN file;
- Receiving a 112 Trigger from ASPEN but no Nursing Facility Packet from a facility; or,
- MCOs wanting more information for a specific member or potential member related to NF LOC.

The Excel Spreadsheet Template *((MCO) MCO Inquiries for Nursing Facility – NFLOC)* has been provided to each MCO to submit and request information from LTSSB. An MCO can request more specific information that is shown in ASPEN or Omnicaid such as:

- 112 Trigger Date and Category of Eligibility (COE)
- Request that a 112 Trigger be sent
- MCO Verification
- MCIID Number
- Name of Nursing Facility
- Long Term Care Status date at Nursing Facility
- SOC (Setting of Care) Status
- COE status or general information related to approval or eligibility denial that affects if a 112 Trigger will be sent to the MCO

To request information, the MCO submits (upload/send) the *(MCO) MCO Inquiries for Nursing Facility - NFLOC Excel Spreadsheet Form* over the Conduent (DMZ) Enterprise Managed File Transfer to: Distribution/NM Operations/(*MCO Name)*/NF-ASPEN/To State. LTSSB will receive notification from the DMZ and download the MCO request spreadsheet and review each submission.

(MCO) MCO Inquiries for Nursing Facility - NFLOC Excel Spreadsheet Form:

The MCO will list each individual alphabetically and include the following information:

Last Name	First Name	DOB	SSN	Nursing Facility Name	NF Packet Received (Yes or No)	COE (if known)	112 Trigger Date (if received)	Applied for IC? (if known)	MCO Action Requested to LTSSB

The MCO is to include the date of the request on the spreadsheet, which should be the same date as the submission date to the DMZ.

LTSSB will send the spreadsheet back to the MCO with the following:

LTSSB Response	MCO Assigned	ASPEN MCIID #	LTSSB Inquiry to ISD (Date)

LTSSB will review each submission request by the MCO and provided information. Response time from LTSSB will vary depending upon additional information requests to ISD or other parties relative to the request.

LTSSB will complete the HCA/LTSSB section of the spreadsheet and return it to the individuals the MCO has supplied as respondents to this request. LTSSB will send the information via email and will encrypt the spreadsheet with an identified “password” that is utilized by the MCO for this purpose. The MCO should review the returned information and determine any next steps.

The spreadsheet returned to the MCO will have a “reply” or “follow-up” and date in the document name.

When information is not yet available to LTSSB the MCO may receive one or more follow-up spreadsheets with updated information.

6.7. 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.

6.8. 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.

  Initial length of stays:
    - Initial HNF is not to exceed thirty (30) days; however, a shorter length of stay can be assigned based on the needs of the resident;
    - Initial LNF cannot exceed ninety (90) days; however, a shorter length of stay can be assigned based on the needs of the resident.
- 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.

  Continued stay length of stays:

- HNF continued stay reviews can be certified by the MCO for up to 90 days based on the medical needs and stability of the resident.
- LNF continued stay reviews can be certified by the MCO up to 365 days based on the medical needs and stability of the resident.

Prior approval reviews are required for all requests for the continued stay of a resident in a NF. These reviews are based on the medical necessity of NF services being continually provided to the resident. The medical necessity decision is made during the continued stay review. Thirty days before the expiration of the current certification, a request for continued stay must be received by the MCO.

- 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 a NF pending Medicaid financial eligibility, the NF submits a completed Minimum Data Set (MDS) with required documentation and a Physician's, Nurse Practitioner's or Physician Assistant's order for LOC. The Notification Form - Section I. Nursing Facility Prior Authorization Request - should have **"MEDICAID PENDING"** selected for Type of Request (Choose an item from the drop-down menu).
  - The MCO will review the information submitted and determine the NF LOC.
  - The MCO will issue NF LOC, if appropriate but will only issue a prior authorization to the NF for the authorized bed days, and after eligibility is established.
  - 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.

6.9. 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
  - 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.

6.10. 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.

6.11. 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 readmit 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 readmitted to the NF and has more than 30 calendar days left on their certification, days will be assigned from the readmit 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 their certification, the NF will not submit a readmit notification form. Instead the NF should submit a redetermination (annual or continued stay) request on the notification form along with supporting documentation.

6.12. Current/Retrospective Reviews

Medical documentation for initial, redetermination, readmit 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 readmit 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. The MCOs may establish a process for unexcused late reviews and will communicate the established process to providers and HCA before implementing.

Excused Late Reviews

Prior authorization forms not submitted in a timely manner 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 their 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.

6.13. 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.

6.14. 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.

6.15. 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.

6.16. Re-Review, Reconsideration, Appeal, Administrative Hearing

- **Re-review:** The Re-review must be requested within ten (10) calendar days after the date on the written notification of the MCO decision or action. Requests for a Re-review must be submitted in writing directly to the MCO. The MCO completes and submits a written Re-review decision to the NF within six (6) business days from receipt and will include the decision and information on the Reconsideration process. Providers who do not meet the ten (10) calendar days for a Re-review may request a Reconsideration.
- **Reconsideration:** Providers who disagree with a Re-Review NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on their behalf. Requests for reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the Re-Review decision notice. The MCO completes and submits a written Reconsideration decision to the NF within ten (10) business days of receipt and will include the decision and information on the MCO Appeals and HCA Administrative Hearing process, as appropriate. The provider or eligible recipient may file a written request for Reconsideration up to 14 calendar days past the 30-calendar day limit if the MCO finds there was "good cause" for failure to file a timely request. The provider or the eligible recipient is responsible for providing written documentation supporting "good cause" for failure to file a timely request. "Good cause" includes a death in the family, disabling personal illness, other significant emergency or executional circumstance.
    - 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.

Individuals employed with the MCO, who were not participants in the initial decision, conduct the Reconsideration review.

The MCO reviews the information and findings upon which the initial action was based, and any additional information submitted to, or otherwise obtained by, the MCO. The information can include the following:

- case records and other applicable documents submitted to the MCO by the provider when the request for services was initially submitted;
- findings of the reviewer resulting in the initial decision;
- complete record of the service(s) provided, including hospital or medical records; and
- additional documents submitted by the provider to support a Reconsideration review.

The MCO performs the Reconsideration and furnishes the Reconsideration decision within ten (10) business days of receipt of the Reconsideration request.

The MCO gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient the notice includes information on the eligible recipient's right to an MCO appeal, HCA Administrative Fair Hearings, timeframes to file an appeal or fair hearing, and how to request continuation of benefits, as applicable.

- **Appeal:** If a reconsideration determination is adverse to the Member, the Member may request an appeal with their MCO in accordance with 8.308.15 NMAC.
- **State Administrative Fair 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.

6.17. Communication Forms

The MCO shall use the approved HCA forms at https://www.hca.nm.gov/providers/nursing-facility-level-of-care for communication and notification with the NFs.

6.18. External Audits of NF LOC Determinations

HCA 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 HCA or its designee for review. HCA or its designee will meet with the MCO to discuss audit findings.

6.19. MCO Internal Audits of NF LOC Determinations

Each MCO will conduct internal random sample audits of both facility and Community Benefit NF LOC determinations based on HCA 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 HCA 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 "MCOname.Q1.18.internal audit results."

6.20. Nursing Facility (NF) Ventilator Services

MCOs shall be required to implement an add-on rate for Ventilator Services provided in long-term and skilled nursing facilities in New Mexico.

1. The nursing facility per diem add-on for a ventilator dependent resident will be $305.66.

2. The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report.

3. Ventilator dependent per diem add-on rates will cover all skilled nursing care services and will be all-inclusive.

4. The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the New Mexico Medicaid nursing home per diem rate determined for the facility.

Long-term and skilled nursing facilities in New Mexico must be certified by the Department of Health (DOH) to provide ventilator services.

Clinical Criteria for Vent Wing

To be eligible for the ventilator add-on services, the recipient must:

1. Have a health condition that requires close medical supervision defined as 24 hours a day of licensed nursing care along with specialized service or equipment;

2. Require mechanical ventilation greater than or equal to six hours a day;

3. Have tracheostomy (with daily care) and require mechanical ventilation for a portion of each day for stabilization;

4. Require continuous pulse oximetry monitoring to check the stability of oxygen saturation levels;

5. Require respiratory assessment and daily documentation by a licensed respiratory therapist or registered nurse;

6. Have a provider's order for respiratory care to include suctioning as needed;

7. Have tracheostomy care with suctioning and room air mist or oxygen as needed, and one of the four treatment procedures listed below:

- o Total parenteral nutrition
- o Inpatient physical, occupational, and/or speech therapy
- o Tube feeding (nasogastric or gastrostomy)
- o Inhalation therapy treatments every shift and a minimum of four times per 24-hour period

8. The recipient's diagnosis must be consistent with ICD diagnosis codes for ventilator dependency;

9. The skilled nursing facility must be approved for ventilator care;

10. Providers must be specially trained and competent in respiratory and vent care.

Vent Wing Procedure Codes, Diagnosis Code and Rate

Long-term and skilled nursing facilities in New Mexico that provide Ventilator Services that meet the clinical criteria can bill the add-on service with the following claim information:

Provider Type	Revenue Code	Description	Rate	Effective Date
211 or 212	0947	Other therapeutic svcs-complex medical equipment ancillary	$305.66	March 14, 2022

Append CPT 94004-Nursing facility ventilation assistance and management to revenue code on above table. The claim must also reflect an ICD-10 diagnosis code of Z99.11-Dependence on respirator (ventilator) status.

6.21. Short-Term Stays

Providers will use revenue code 0190 when billing for non-skilled, non-hospice short-term stays in a Nursing Facility (NF) for less than 90 days. These stays do not require a Nursing Facility Level of Care (NF LOC). The MCOs must reimburse the NF at the NF's contracted rate for a Low NF (LNF) stay, and there are no High NF (HNF) determinations or Institutional Settings of Care (SOCs) issued for these types of stays. The non-skilled, non-hospice short-term stay is provided under the Member's physical health benefit.

6.22. MCO Termination on NF Contract

If an MCO decides to terminate its contract with a Nursing Facility, it must follow the approved process in the MCO contract with HCA and submit a transition plan to HCA for all impacted Members per Section 2 of this manual. The MCO will collaborate with HCA, ALTSD and DOH staff to ensure a successful transition for all of its Members to another MCO, to another NF or to the community. The MCO will provide documents to include the rationale for its decision to terminate the contract to the HCA upon request. The MCO will work closely with the NF to ensure that all authorization and claims issues are addressed. The HCA will communicate the termination to other MCOs.

6.23 Closure of a Nursing Facility

When HCA is notified about a pending closure of a NF, it will notify the MCOs of the closure and will request a census of impacted Members from each MCO. The MCOs must follow the process outlined in Section 2 of this manual. HCA will require ongoing weekly updates from each MCO on their progress with transitioning Members to other settings. Throughout the closure and transition process, the MCOs will collaborate with HCA, ALTSD and DOH staff, including the ALTSD ombudsman. The MCOs will work closely with the NF to ensure that all authorization and claims issues are addressed.

6.24. Tribal 638 Nursing Facilities

Tribal 638 Nursing Facilities (NFs) are to be reimbursed for NF services at the Outpatient OMB rate. Approved NFs will have an Indian Health Service (IHS) indicator on the provider enrollment file.

MCOs will not pay less than the current calendar year OMB rate for Tribal 638 nursing facilities under the authority of 42 CFR 438.14(c)(2).

For approved NFs, there will be one single daily rate for both High Nursing Facility (HNF) and Low Nursing Facility (LNF). The rate is published annually by CMS as the Outpatient OMB rate. For an approved NF to receive the Outpatient OMB rate, the member must meet a LNF in accordance with the NF LOC Criteria Instructions 2019 that may be found at

https://www.hsd.state.nm.us/providers/nursing-facility-level-of-care/

The MCOs are to reimburse for reserve bed days at a rate of one-half of the Outpatient OMB rate in accordance with 8.312.2.16D NMAC.

6.25. Denial of Payment for New Admissions (DPNA)

Under the Social Security Act at §§1819(h) and 1919(h) and CMS's regulations at 42 CFR 488.417, CMS may impose a Denial of Payment for New Admissions (DPNA) against a Nursing or Long-Term Care Facility when CMS finds that a facility (1) fails to be in substantial compliance for three months after the last day of the survey identifying the noncompliance, or (2) is found to have provided substandard quality of care on the last three consecutive standard surveys. DPNA notifications are sent to HCA from CMS. HCA will then, in turn, send the information to all MCOs through the deliverable process. The alert will include information about the facility with the penalty and the dates which the DPNA will apply. Alerts may be for dates which have already passed.

MCO must determine if they have members who are admitted into the named facility during the listed dates. MCO should continue to monitor billing for the dates in question to make sure all potential admissions are included. Please note, the DPNA applies to new admissions into the facility and not established residents. If the MCO determines the criteria does not apply to any of their members, no action is needed. If it does apply to any member, the MCO is required to recover any payments made to the facility for said member for the outlined time period. The entity (facility) is responsible and subject to the financial penalty, not the MCO or the member. Therefore, the MCO must ensure that the resident/member is not then held responsible for the payment recovered by the MCO. Also, this will not impact the capitation received by the MCO for the member. The member will still have Medicaid eligibility and will still need to complete all steps to keep eligibility, including paying any required PPA.

7. Community Benefits

7.1. General Information

The Community Benefits (CB) are services that provide assistance to individuals who require Long-Term Services and Supports (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 Nursing Facility. The CB does not provide 24-hour care and is 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 Comprehensive Needs Assessment (CNA). Members eligible for the CB have the option of selecting either the Agency Based Community Benefit (ABCB) or Self-Directed Community Benefit (SDCB). Two eligibility components must be met prior to receiving CB services: financial eligibility, determined by HCA/ISD, and medical eligibility, determined by an MCO through a NF LOC assessment conducted as part of the CNA. Additionally, if an individual is under the age of 65 and has not been deemed disabled by the Social Security Administration (SSA), they must be evaluated by MAD's Disability Determination Unit (DDU) to establish their disability meets SSA guidelines. See NMAC 8.290.400.10(A).

Members who have a Full Coverage Medicaid COE may be eligible for CB if they meet an NF LOC and indicate they have a need for CB. These individuals may be identified by their MCO or may 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 they have a need for CB and meets an NF LOC, an allocation is not needed to access CB services.

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 their CB services.
4. **Allocation:** The opportunity given to a registrant who is Not Otherwise Medicaid Eligible (NOME) to apply for CB.
5. **Allocation Packet:** The documents sent by HCA/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 CB 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. **HCA 100:** "Medicaid Application for Assistance" that is used to apply for CB and is available online or at a local HCA/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 them that an allocation is available and that they may apply for CB.
11. **Notice of Allocation (NOA):** The letter that is sent to a registrant informing them that the PFOC was received at HCA/MAD/LTSSB and informs them 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 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 their 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 chooses to self-direct their CB services.
15. **Signature:** Signature of Member or Member's legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice. Wherever signature is required, verified electronic signature may be used.
16. **Telephonic Signature:** When a Member or Member's legal representative fails to sign required documents, a telephonic signature may be obtained by an authorized HCA staff member. The staff member will verify the member's identity and note that a telephonic signature was collected.
17. **Verified Electronic Signature:** A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication.
18. **Withdrawal Form:** The form that is contained in the Allocation Packet that allows a registrant to withdraw their request to apply for CB services.

7.3. Nursing Facility Level of Care (NF LOC)

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 coverage Medicaid COE do not need an allocation to access CB. The Member must contact their MCO Care Coordinator to request an NF LOC evaluation to determine if medical eligibility can be established. The Member's MCO may also identify the Member as having a need for CB and discuss with the Member. 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. CNA dates may be adjusted annually or as indicated to align with NFLOC CNA to eliminate need for redundant CNAs. 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.

The MCO shall submit the NF LOC effective date spans and SOC date spans via the applicable interface(s) within 24-hours (one business day) of determination. For renewals, this submission should be no later than 60 calendar days prior to the expiration of the existing NF LOC and SOC date spans. If the NF LOC determination has not been completed 60 days prior to expiration due to member caused delay, the NF LOC must be submitted as soon as possible to avoid any lapse in coverage.

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

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

7.5. External Audits of NF LOC Determinations

HCA 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 HCA or its designee for review. HCA or its designee will meet with the MCO to discuss audit findings.

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 HCA 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 HCA 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 "MCOname.Q1.18.internal audit results."

7.7. Registration for the CB for Not Otherwise Medicaid Eligible (NOME) Members

The ALTSD/ADRC (referred to as ADRC from this point forward) manages the CB Central Registry by enrolling individuals, completing the preassessment, assigning the category of registration, and sending Exception requests to HCA/MAD/LTSSB. Any individual has the right to place their 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 their 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 90 consecutive days, the registrant may have been hospitalized and returned to the NF for the remainder of the 90 days. If the 90-day stay was confined to only a hospital stay and the client was never in a NF this does not qualify them for a CRI, they would have to be evaluated under another allocation type such as Regular or Exception. 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 their home. The intent of CRI is to assist the individual to become integrated into their 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 HCA.

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

Once the PFOC and HCA 100 are received by HCA/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 HCA/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.
- **Regular (REG)** – a registrant who does not meet the criteria for any of the other registration types, based upon the ADRC preassessment.
- **Exception (EXC)-** 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 HCA/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 their full Medicaid eligibility terminated. An individual must inform the ADRC that they have 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.

7.8. Allocation Process

The ADRC manages the Central Registry by enrolling individuals, completing the preassessment, and sending Exception requests to HCA/MAD. The HCA/MAD/LTSSB manages the allocation process by mailing Allocation Packets to registrants and forwarding completed allocation paperwork to HCA/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 HCA/MAD Director determines that an 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 HCA 100, or a Withdrawal Form. The Allocation Packet contains the following:

- LOI;
- PFOC;
- Withdrawal Form;
- HCA 100 "Medicaid Application for Assistance";
- CBs Informational Brochure; and
- Business Reply envelope addressed to HCA/MAD/LTSSB.

Timeframes for the Allocation Packet:

- The registrant has 45 calendar days to return either a completed PFOC and HCA 100, or a Withdrawal Form to HCA/MAD/LTSSB.
- The registrant may request a onetime extension to return the PFOC and HCA 100, or Withdrawal Form by contacting the HCA/MAD/LTSSB, and if requested, it shall be granted for up to 30 calendar days. Any additional time (extensions) requested by the registrant must be made directly to HCA/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, HCA/MAD/LTSSB shall send a closure letter to the registrant's mailing address on file.

Processing PFOC and HCA 100s:

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

- HCA/MAD/LTSSB will attempt contact the registrant to complete the PFOC with a telephonic signature while verifying the contact/demographic information. If MAD is unable to reach the registrant the PFOC will be mailed to the registrant, identifying the information required, and provide the registrant up to 30 calendar days to complete and return the form. Failure to return the PFOC within the 30 calendar days or within the 45th day whichever is later will result in closure, as described herein.

- If the HCA 100 is not complete and/or signed, then the form(s) will be returned to the registrant, identifying the information required, and provide the registrant up to 30 calendar days to complete and return the form. Failure to return the HCA 100 within the 30 calendar days or within the 45th day, whichever is later, will result in a closure, as described herein.
- When the PFOC and HCA 100 are complete and with signature, the forms will be date stamped with the same date the NOA was sent to the registrant. The authorized HCA/MAD/LTSSB staff will initial under the date stamp.
- If the PFOC **and** HCA 100 are completed and signed, HCA/MAD/LTSSB will process them by sending:
  - A NOA letter to the registrant;
  - A copy of the PFOC and HCA 100 to the HCA/ISD Eligibility system; and
  - A copy of the PFOC to the registrant's MCO.

7.9. Eligibility

Once the PFOC and HCA 100 have been distributed to HCA/ISD and the MCO, HCA/MAD/LTSSB's "Processing PFOCs" is complete. HCA/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 MCOs must have established procedures for their call centers to resolve issues and address inquiries from those who are allocated, but not yet fully enrolled with the MCO, because the NFLOC determination has not yet been completed. The MCO must be able to identify these individuals in their systems within two (2) business days of receipt of the PFOC or 112 trigger file sent from the ASPEN system and be able to address questions and concerns from these future Members who are newly allocated and may be enrolled in the MCO when eligibility is complete. If there is an existing/current NF LOC in the HCA/ISD eligibility system, there will be no 112 trigger file sent to the MCO. The MCO should reach out to HCA/MAD/LTSSB staff if they receive the trigger file and no PFOC or vice versa.
    - 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 HCA/ISD, via the interface file, within 5 business days of the NF LOC determination so it can be used by HCA/ISD to complete the eligibility process.
    - If there is an existing NF LOC determination, the MCO shall submit the NF LOC effective dates to HCA/ISD, via the interface file, within 5 business days of the MCO's receipt of the PFOC so it can be used by HCA/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.
    - If an individual is under the age of 65 and has not been deemed disabled by the Social Security Administration (SSA), they must be evaluated by MAD's Disability Determination Unit to establish whether they meet the disability criteria according to SSA guidelines. Current medical records regarding the individual's disability must be provided to ISD.

- **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 nonfinancial eligibility requirements must be met as determined by HCA/ISD.

Once eligibility is approved by HCA/ISD, the registrant's ABCB services will be provided based on the CNA conducted by the Member's MCO. Although the COE for the CB Waiver is approved, CB services will not begin until the Comprehensive Care Plan is in place. CB services are not approved retroactively.

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 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.

7.10. Closing/Inactivating an Allocation

An allocation will be inactivated by HCA/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 HCA/MAD/LTSSB is informed the registrant intends to remain in the NF;
- The ADRC or HCA/MAD/LTSSB is informed the registrant is no longer a resident of the State of New Mexico;
- The ADRC or HCA/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.

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.

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, HCA/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 HCA/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. HCA/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.

8. Agency-Based Community Benefits (ABCB)

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 Personal Care Services (PCS).

- Home and Community Based Services (HCBS) shall meet all requirements of the HCBS Final Rule for Settings including the following requirements: Are integrated and support full access of Members 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 Member from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered care plan and are based on the Member's needs and preferences;
- Ensure a Member's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize, but do not regiment, Member's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact; and
- Facilitate Member choice regarding services and supports, and who provides them.
  HCA will take the following factors into account when determining whether a setting may have the effect of isolating Members receiving Medicaid HCBS from the broader community of Members not receiving HCBS:
    - Due to the design or model of service provision in the setting, Members have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS. Opportunities as well as identified supports to provide access to and participation in the broader community, should be reflected in both the Member's person-centered care plans and policies and practices of the provider setting in accordance with 42 CFR 441.301(c)(1)(3) and (4)(vi)(F), 42 CFR 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR 441.710(a)(1)(vi)(F) and 441.725;

- The setting restricts Member choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate Member opportunity to access the broader community and participate in community services, consistent with the Member's person-centered care plan.

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 Not Otherwise Medicaid Eligible (NOME).
3. **Annual:** The 12-month period covered by a Comprehensive 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 Skilled Nursing Facility (SNF) into a community placement, after a 90-day continuous stay.
8. **Comprehensive Care Plan (CCP):** A comprehensive plan of services that meets the Member's physical, behavioral, and long-term needs.
9. **Consumer Delegated:** The consumer delegated model allows the Member to select their Personal Care Services (PCS) agency to perform all PCS employer-related tasks. This agency is responsible for ensuring all PCS are delivered to the Member.
10. **Consumer Directed:** The consumer-directed model allows the Member to oversee their own PCS delivery, and requires that the Member work with their PCS agency who then acts as a fiscal intermediary agency to process all financial paperwork to be submitted to the MCO.
11. **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.
12. **Face-to-Face:** Being in the physical presence of the individual who is receiving services.
13. **Healthcare Authority (HCA):** Designated by CMS as the Medicaid administering agency in New Mexico.
14. **Home Delivered Medically Tailored Meals (MTM):** MTMs are fully prepared meals that are designed by a registered dietitian nutritionist (RDN) to meet the unique nutritional requirements of members with various health conditions. CB MTMs should incorporate local agriculture, local food vendors and local food preparation services to the extent practicable.

15. **Interdisciplinary Team (IDT):** IDT, consisting of the Member, the legal Authorized Representative (AR), the family, service providers and other people invited by the Member and the legal authority representative, if applicable.
16. **Immediate Family Member:** Father (includes natural or adoptive father, father-in-law, stepparent), mother (includes natural or adoptive mother, mother-in-law, stepparent), sibling (includes half sibling, stepsibling), child, stepchild, adoptive child, natural grandfather, natural grandmother, and spouse relationship to the individual.
17. **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.
18. **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.
19. **Medical Assistance Division (MAD):** The MAD, New Mexico Healthcare Authority.
20. **Natural Supports:** Supports not paid for with Medicaid funds that assist the individual to attain the goals as identified on the Comprehensive 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.
21. **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.
22. **Parent:** Natural or adoptive mother or father, or stepmother, stepfather.
23. **Person-Centered Care Plan (PCCP):** A procedural plan that describes the provision of specified activities and oversight on a routine basis in order to safeguard the health of the Member.
24. **Primary Caregiver:** The person who takes primary responsibility for someone who cannot carefully for themselves. The primary caregiver may be a family Member, a trained professional or another individual.
25. **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.

26. **Signature:** Signature of Member or Member's legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice. Wherever signature is required, verified electronic signature may be used.
27. **Verified Electronic Signature:** A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication. An agency may use their choice of authentication method, which must be outlined in the company's manual/training materials.

8.3. ABCB Services Requirements

These requirements apply to the services provided through the Medicaid 1115 Waiver for Members 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 an active Medicaid approved provider type 363 (Community Benefit Provider) and have HCA/MAD approval to provide that service. All incomplete applications submitted to the HCA/MAD Long-Term Services and Supports Bureau (LTSSB) shall be rejected and not considered for review until a complete application is submitted.

The requirements address each service covered by ABCB. Members served through this program will expect to receive services that meet these requirements. The MCO must document each member's choice of CB settings in the CCP. MCOs must contract with an active ABCB Medicaid approved provider type 363 that has approval from HCA/MAD to provide that service before rendering CBs to Members. Eligible ABCB providers are those that have been approved and certified by the HCA/MAD/LTSSB, per 8.308.2.9 NMAC *Managed Care Program, Provider Network*. Each MCO must ensure that it has an adequate statewide provider for all ABCB Services.

These requirements define the services offered as approved by CMS. The ABCB services are a supplement to the Member's natural supports and are not intended to replace family supports. 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 a Nursing Facility. The ABCB services are implemented in accordance with the Person-Centered Care Plan (PCCP) and/or Comprehensive Care Plan (CCP) as developed by the Member and the MCO Care Coordinator. The PCCP must revolve around the ABCB Member and reflect their chosen lifestyle, cultural, functional, and social needs for successful community living.

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;
- Home Delivered Meals
- Home Health Aide;
- Nutritional Counseling;
- Personal Care – Consumer Directed;
- Personal Care – Consumer Delegated;
- Private Duty Nursing (PDN);
- Nursing Respite;
- Respite; and
- Skilled Maintenance Therapy Services.
    - Occupational Therapy for Adults
    - Physical Therapy for Adults
    - Speech Therapy for Adults

All ABCB providers are required to participate in an annual audit conducted by the MCOs. The review includes an assessment of each provider's compliance with the HCBS Settings Rule. Failure to respond to the MCO audit and/or correct identified issues may lead to provider termination from the CB program.

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 Members as determined by the PCCP incorporated into

the CCP. Adult Day Health settings must be integrated and support full access of Members 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 Day Care Center, that offers health and social services to assist Members to achieve optimal functioning. 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 Care Center must be coordinated by the Adult Day Care provider. Adult Day Health Centers must be physically located in New Mexico.

PDN services and Skilled Maintenance Therapies (physical, occupational, and speech) may be provided in conjunction with Adult Day Health services, by the Adult Day Care provider or by another qualified provider. PDN and therapy services must be provided by licensed nurses and therapists. The PDN and Skilled Maintenance Therapies must be provided in a private setting at the facility.

Scope of Services/Requirements:

- The health, safety, and welfare of the Member must be the primary concern of all activities and services provided. Provider staff must supervise all activities. Activities provided by the Adult Day Care Center are included in the negotiated rate with the MCO and are not billed separately. Specific services may include the following:
  - Coordination of transportation to and from the Adult Day Care 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;
  - Activities that provide for group interaction in social and instructional programs and therapeutic activities;
  - Personal Care Services (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 PCCP will be adjusted as necessary to meet the needs of the Member at the quarterly meeting or at other times as needed. A PCCP will be developed with identified goals and measurable objectives. It will be attached to or incorporated into the CCP.
- All activities must be supervised by provider staff. Members must never be left unattended. Adult Day Care Center staff 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; and
  - Provide for group interaction in social and instruction programs and therapeutic activities.

Provider Requirements/Qualifications:

- Adult day health services may be provided by eligible adult day care agencies.
- Adult Day Care Centers must maintain (no gaps in licensure) a full permanent license 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. Provisional licenses will not be accepted.
- Adult Day Care Centers must comply with the provisions of Title II and III of the Americans with Disabilities Act (ADA) of 1990, P.L. 101-336 (42 U.S.C. Section 12101, et seq.).
- In order to be approved and certified by the HCASD/MAD/LTSSB Adult Day Care Centers must be operating with a permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Adult Day Care Centers must comply with all applicable cities, county or state regulations governing transportation services, if providing transportation services to its Members.

- Adult Day Care Centers must comply with the HCA/MAD requirements including but not limited to: OSHA training requirements; incident management reporting; criminal background check (CBC); labor laws, etc.
- Adult Day Care 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 CCP to the Adult Day Care Services Provider.
- A written Adult Day Health Services PCCP will include the assessment of the special needs, the interventions to meet those needs, and evaluation of the plan, with changes as needed. The PCCP will be provided to the MCO Care Coordinator and must be incorporated into the Member's CCP.
- 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 and included in the MCO negotiated hourly rate. 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 this 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

The Member must attend the Adult Day Care Center for a minimum of two hours per day for one or more days per week and the frequency (number of days per week) of attendance at the center must be included in the individual's PCCP and the CCP.

8.6. Assisted Living Facility (ALF)

Assisted living facilities offer residential services that provide a homelike environment which may be in a group setting with individualized services designed to respond to the Member's needs as identified by the Member, provider, and the Care Coordinator. A PCCP is developed with the Member that needs

services in the ALF and incorporated in the CCP. Assisted living services include assistance with Activities of Daily Living (ADLs) (i.e., ability to perform tasks that are essential for self-care, such as bathing, feeding oneself, dressing, toileting, and transferring) and assistance with Instrumental Activities of Daily Living (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- Residents must have the ability to control their own schedules and activities;
- Treating each Member with dignity and respect;
- Promoting the individuality of each Member;
- Allowing each Member choice in care and lifestyle;
- Protecting each Member's right to privacy;
- Nurturing the spirit of each Member;
- Involving family and friends in care planning and implementation;
- Providing a safe residential environment; and
- Providing safe community outings or activities that facilitate community inclusion.

Scope of Services/Requirements:

- 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- residents may have visitors of their choice at any time;
  - Opportunities for individual and group interaction;
  - Housekeeping;
  - Laundry;
  - Transportation- :The ALF may provide transportation to members, and if ALF provided transportation is not available, the ALF must assist residents in arranging transportation as needed;

- Meal preparation and dining,- food must be available to residents at all times;
- 24-hour, on-site response capability to meet scheduled or unpredictable Member 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 PCCP;
- Implementation of the PCCP to meet the Member's needs, evaluation for effectiveness, and adaptation as needs change;
- Services provided to a resident at an ALF are pursuant to the PCCP, developed by the Member, provider and the MCO Care Coordinator; and/or
- Other direct services (not listed above as core services) that provide assistance to the Member in meeting a broad range of ADLs. Direct services may be provided by the ALF or may be provided by another ABCB active, Medicaid approved type 363 provider with HCA/MAD approval to provide that service. These direct care providers must be identified on the Member's PCCP, that is separate from the CCP, and might include:
  - PDN services for Adults (see the Scope of Services/Requirements for PDN); and/or
  - Skilled Maintenance Therapies for Adults (see the Scope of Services/Requirements for Skilled Maintenance Therapies); and/or
  - Adult Day Health.

Provider Requirements/Qualifications:

- Assisted Living Services must be provided by an active, Medicaid approved provider type 363 Assisted Living Facility (ALF).
- ALF must maintain (no gaps in licensure) a full permanent license by Licensing and Certification Bureau, Division of Health Improvement/Department of Health. Provisional licenses will not be accepted.
- ALF 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.).
- The ALF must be located in the State of New Mexico.
- In order to be approved and certified by the HCA/MAD/LTSSB, ALF must be holding and operating with a fully approved permanent license. All incomplete applications submitted to the

HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.

- Assisted Living providers must ensure that personnel providing direct services (directly employed by the ALF or through a contract for services) meet all requirements established by HCA/MAD for direct services such as, PDN, and skilled maintenance therapies (see Provider Requirements/Qualifications for each separate service).
- Assisted Living providers are required to maintain staffing ratios and patterns that will meet the Member's needs as identified in the PCCP and the CCP.
- Assisted Living providers will develop a PCCP for each Member based on the assessment of the needs of the Member and include strategies to meet those needs. The PCCP must be evaluated for effectiveness and revised as the needs of the Member change. The PCCP is separate and incorporated into the CCP.
- Assisted Living providers will develop a written agreement with each ABCB Member residing in their ALF. This agreement will detail all aspects of care to be provided including identified risk factors.. It will also include the financial agreement regarding the cost of room and board and the funding sources. A copy of this agreement and any later revisions must be forwarded to the MCO Care Coordinator 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.
- Members shall be afforded the same protections from eviction as all tenants under landlord law of state, county, city or other designated entity. This includes, but is not limited to, the resident's right to an eviction hearing in district or magistrate court.
    - If an ALF must terminate a lease or evict a resident at will, written notice must be provided to the resident. This notice must include the reasons for termination of the lease and allow the resident 30 calendar days before they must vacate.
    - If a resident has their lease terminated/evicted, their MCO Care Coordinator must work with them to find appropriate alternative housing/placement.
    -
- Assisted Living providers must meet all requirements set forth by the Licensing and Certification Bureau/Department of Health. This would include the definition of a homelike environment described below:

- Providers must meet the minimum, applicable qualifications set forth by the Licensing and Certification Bureau of the Department of Health and HCA/MAD, including but not limited to: labor/staffing rules and regulations; criminal background checks; employee abuse registry; incident management reporting; OSHA training requirements, etc.
- Definition of Homelike Environment: A homelike environment must possess the following structural features prior to the placement of the ABCB Member. 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 HCA/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:
        - All Members must be given the option to receive HCBS in more than one residential setting appropriate to their needs;

- Private or semiprivate 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. Members must have access to food storage or food pantry area at all times, including at night. Members must be allowed their choice of what to eat and when they eat.
- ; Private or semiprivate bathrooms that include provisions for privacy;
- Common living areas and shared common space for interaction between Members, their guests, and other residents;
- 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 of day or night, and being allowed privacy when visiting, making phone calls at any time of day or night, and being allowed privacy when making or receiving call; and being in their home and in the community when they so choose;
- Members will be treated with respect, choose to wear their own clothing, have private space for their personal items, , 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 only 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 PCCP to address the following:
  - Identify a specific and individualized assessed need;
  - Document the positive interventions and supports used prior to any modifications to the PCCP;

- 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;
- 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 Member; and
- Include an assurance that interventions and supports will cause no harm to the Member.

Reimbursement

Billing for Assisted Living services is based on a daily rate which includes core services such as personal care. Reimbursement for Assisted Living 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 must contact the MCO immediately to have the error corrected. An ALF may not bill the MCO for services that the prior authorization does not cover.

Limits or Exclusions

Assisted Living services includes core services, such as, but not limited to: personal care, transportation and meal preparation. These services cannot be billed separately. ALF services include the following ABCB services:

- Personal care services ;
- Respite;
- Environmental Modifications; and
- Emergency Response.

The Assisted Living provider is responsible for all of these services in the ALF. Therefore, billing for these services in addition to the Assisted Living services would constitute duplication of services. Assisted

Living services require a prior authorization from a Turquoise Care MCO and will not be approved retroactively.

- 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 Members must be reported to the HCA/MAD along with the Medicaid Provider Participation Agreement (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 HCA/MAD when they occur;
  - The provider 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 and is included in the daily rate negotiated with the MCO.
- Non-Billable Activities
  - Assisted Living providers will not bill the MCO for Room and Board;
  - General training requirements are an administrative cost and are not billable; and

    The Provider will not bill when a Member is hospitalized or in an institutional care setting.

If an MCO decides to terminate its contract with an ALF, it must follow the approved process per Section 4.9 of the MCO contract with HCA and submit a transition plan to HCA for all impacted Members in accordance with the requirements in Section 2 of this manual. The MCO will collaborate with HCA, ALTSD and DOH staff to ensure a successful transition for all of its Members to another MCO, to another ALF or to the community. The MCO will provide documents to include the rationale for its decision to terminate the contract to the HCA upon request. HCA will notify the other MCOs of the termination. The MCO will work closely with the ALF to ensure that all authorization and claims issues are addressed.

When HCA is notified about the closure of an ALF, it will notify the MCOs of the closure and will request a census of impacted Members from each MCO in addition to the forms required in Section 2 of this manual. HCA will require ongoing weekly updates from each MCO on their progress with transitioning Members to other settings. Throughout the closure and transition process, the MCOs will collaborate

with HCA, ALTSD and DOH staff, including the ALTSD ombudsman. The MCOs will work closely with the ALF to ensure that all authorization and claims issues are addressed.

8.7. Behavior Support Consultation (BSC)

A Behavior Support Consultant is a licensed professional as specified by applicable State laws and standards. BSC services assist the Member and their family as well as the direct support professionals (DSP). BSC 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/Requirements:

BSC services are initiated when the MCO Care Coordinator identifies and recommends the service be provided to the Member/Member's representative and/or family Member(s). The Care Coordinator is responsible for including recommended units of BSC services into the CCP. Strategies, support plans, goals and outcomes will be developed based on the identified strengths, concerns and priorities in the PCCP.

BSC services include:

- Providing assessments, evaluations, development of treatment plans and interventions, training, monitoring of the Member/Member 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 Member/Member representative and/or family Member(s) that is supportive of the PCCP;
- 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 Member's PCP and/or other therapists and/or medical personnel for the purposes of evaluation of the Member developing, modifying or monitoring BSC services for the Member;

- Observing the Member/Member representative in all relevant settings in order to monitor the Member's status as it relates to therapeutic goals or implementation of BSC 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 Member to give the appropriate behavior support recommendations, taking into consideration the overall array of services received by the Member. 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 Member'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 Requirements Include:
  - Reason for discontinuing services (such as failure to participate, request from Member/Member representative, goal completion, and/or failure to progress);
  - Written discharge plan shall be provided to the Member/Member representative and the MCO Care Coordinator by the BSC;
  - Strategies developed with Member/Member 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 Member's clinical file maintained by the BSC and a copy is to be sent to the MCO Care Coordinator and distributed to the Member/Member representative.

Other Documentation Requirements:

- Documentation must be completed in accordance with applicable HCA/MAD and Federal guidelines;
- All documents are identified by title of document, Member 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, Member/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;
- Any modifications that need to be included in the PCCP must be coordinated with the MCO Care Coordinator;
- Complications that delay, interrupt, or extend the duration of the program will be documented in the Member's medical record and in communications to the physician/health care provider as indicated;
- Each Member will have an individual clinical file maintained by the provider; and
- Review physician/health care provider orders at least annually and as appropriate and recommend revisions to the PCCP and CCP based on evaluation findings.

Agency Provider Requirements/Qualifications:

- BSC services must be provided by an active, Medicaid approved provider type 363 BSC provider.
- Employees of a provider agency who offer BSC services shall meet all the requirements under this section of the policy.

- The BSC agency must be able to demonstrate that all employees providing BSC, upon employment and thereafter, maintain (no gaps in licensure) a full permanent license through the appropriate board of licensure. Below identifies acceptable licensure for a BSC worker:
  - Master's degree from an accredited school for psychology, social work, counseling, or guidance program and maintain current permanent 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).
    - New Mexico Licensed Professional Clinical Counselor (LPCC).
    - New Mexico Licensed Marriage and Family Therapist (LMFT).
    - New Mexico Licensed Mental Health Counselor (LMHC).
- Maintain a culturally sensitive attentiveness to the needs and preferences of members and their families based upon culture and language. Communicating in a language other than English may be required.

Individual Provider Requirements/Qualifications:

- BSC services must be provided by an active, Medicaid approved provider type 363 BSC provider.
- An individual providing BSC services must maintain a full permanent license through DOH and shall meet all the requirements under this section of the policy. Provisional license is not acceptable.
- Must meet all other requirements listed under Agency Provider Qualifications/Requirements.

Reimbursement:

BSC providers are 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 PCCP

that is coordinated with the Member/Member's representative and other caregivers as applicable. All services provided, claimed, and billed must have documented justification supporting medical necessity and authorized by the MCO.

Billing is on an hourly basis and is accrued to the nearest quarter hour. Training on Member specific issues is reimbursable and included in the negotiated rate. Payment for BSC services through the MCO is considered payment in full. Reimbursement for BSC services will be based on the MCO negotiated rate. BSC providers have the responsibility to review and ensure the information on the prior authorization for their services is current and correct. If the provider identifies an error, they will contact the MCO immediately to have the error corrected.

Limits or Exclusions

HCA/MAD does not consider the following to be professional BSC duties and will not authorize payment for:

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

8.8. Community Transition Services (CTS)

CTS are non-recurring set-up expenses for adults 21 years old and older who are transitioning from a SNF/NF to a living arrangement in the community where the person is directly responsible for their 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. CTS are furnished only when the Member is unable to meet the expenses to initially establish their household or when the services cannot be obtained from other sources. CTS may not be used to furnish or establish living arrangements owned or leased by a service provider, except an ALF. Deposits to an ALF are limited

to $750.00. Services must be reasonable and necessary as determined by the MCO and authorized in the transition and/or discharge plan.

Scope of Services/Requirements:

CTS must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the discharge 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;
- Setup 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
- Fees to obtain a copy of birth certificate, identification card or driver's license.

The Community Transition Agency (CTA) must be able to provide at least two of the following core services:

- Information and referral;
- Independent living skills training;
- Peer counseling; and
- Individual and systems advocacy;

Provider Requirements/Qualifications:

The CTS may be provided directly by the MCO or contracted out to an active, Medicaid approved provider type 363 CTA. The CTA is defined as an agency that provides CTS to individuals who are transitioning from a SNF/NF to a home and community-based residence.

Reimbursement

Reimbursement for CTS will be based on the negotiated rate with the MCO. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and are not billable.

CTS Providers have the responsibility to review the prior authorizations issued from the MCO to ensure that the information on the prior authorization for their services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

Limits or Exclusions

CTS do not include monthly rental or mortgage expense, food, regular utility charges, household appliances or items that are intended for purely diversional/recreational purposes.

Additional exclusions: music systems, cable/internet, TV, VCR, DVD, MP3 player, telephone equipment, computer, exercise equipment, personal hygiene items, decorative items, experimental or prohibited treatments and memberships. CTS are limited to $4,000.00 per person every five years. In order to be eligible for this service, the person must have an SNF/NF stay of at least 90 days prior to transition to the community.

The Care Coordinator must explain this service to the Member prior to discharge as part of the community reintegration process. The Member should request this service prior to discharging from the Nursing Facility. If the Member discharges from the NF to the community against medical advice (AMA) or without MCO acknowledgement, this benefit may not be available.

Payment for a deposit to an ALF is limited to $750.00.

8.9. Emergency Response Services (ERS)

(ERS) are provided through an electronic monitoring system to secure help in the event of an emergency. This service is to be used by ABCB members whose safety is at risk. The Member may use a portable “help” button to allow for mobility in the 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 service agency responds to alarm calls. (ERS) are provided pursuant to the CCP.

Scope of Services/Requirements:

Services provided by the emergency response service provider include:

- 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.

Provider Requirements/Qualifications:

- ERS services must be provided by an active, Medicaid approved provider type 363 ERS provider;
- In order to be approved and certified by the HCA/MAD/LTSSB, ERS providers must meet all provider requirements/qualifications under this section. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- The ERS provider must have emergency monitoring capability 24 hours a day, seven days a week;
- The ERS provider must be able to demonstrate it has professional trained staff to answer and manage the response center;
- The ERS provider must be able to demonstrate it is:
    - Equipped to provide verifiable data using technology capable of producing a printed record of:
        - The type of alarm code (test, accidental or emergency);
        - The unit subscriber number;
        - The date; and
        - The time of the activated alarm in seconds.

  - 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.
- 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 provider 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 MCO 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 on a quarterly basis.
- Emergency Response service providers are not required to have an office located in New Mexico.

Reimbursement

- Reimbursement for (ERS) will be based on the negotiated rate with the MCOs. Providers of service have the responsibility to review and ensure 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 can be billed to the MCO for each calendar month the Member is authorized for use of the service.
- A fee for special equipment (e.g., a 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 (ERS) must be documented in the CCP.
- All rates are based on the negotiated rate with the MCO.

Limits or Exclusions: None

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 a Member 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 Member's CCP. 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 employment supports 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

Employment Supports facilitates competitive 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 members 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. Employment Supports provides assistance such as job coaches, transportation, assistive technology, specialized job training, and individually tailored supervision.

- Basic components of employment supports should seek to 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 employment supports used depend on the needs of the Member. The following are the basic components of employment supports:

- **Paid Employment** - Wages are a major outcome of employment supports. 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 CCP. Members should not receive Employment Supports services through the ABCB program without first exhausting available vocational rehabilitation services. DVR services are considered unavailable if the Member is placed on the DVR waitlist.

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.

Provider Requirements/Qualifications:

- The employment supports services must be provided by an active, Medicaid approved provider type 363, Employment Supports provider;
- The employment supports provider must adhere to all rules and regulations regarding employment supports in this section of the policy and any applicable city, county or state regulations governing employment supports;
- The employment supports provider must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance;

- In order to be approved and certified by the HCA/MAD/LTSSB, Employment support providers must meet all requirements in this section of the policy. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- Provider 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 HCA/MAD. Each Member's earnings and benefits shall be monitored by the provider in accordance with the Fair Labor Standards Act. Each Member's earnings and benefits shall be reviewed at least semi-annually by the Employment Supports provider to ensure the appropriateness of pay rates and benefits;
- The Provider shall maintain a confidential case file for each Member and will include the following items:
  - Quarterly progress reports;
  - Vocational assessment or profile; and
    - Vocational assessments 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 acceptable to the Division of Vocational Rehabilitation (DVR) or HCA/MAD;
  - Career development plan as incorporated in the Comprehensive 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 Reporting Requirements/Qualifications:

The Employment Supports provider shall submit the following to the MCO Care Coordinator;

- Quarterly Progress Reports based upon the Care Plan cycle;
- Vocational Assessment; and
- Written updates, at least every six months, to the Work/Learn Action Plan.

Training Requirements

Providers shall retain staff trained to establish Career Development Plans. Training will be provided by the provider necessary to ensure that employees are able to demonstrate competency in skills listed under this policy.

- 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 Member's needs and outcomes as indicated in the CCP and may vary according to purpose (e.g., job development, job training, job stabilization, career enhancement). For Employment Supports, the staff to individual ratio is 1:1 unless otherwise specified in the CCP. For Individual Employment Supports, a minimum of 1 one-hour face-to-face visit per month is required.

Staffing Requirements and Restrictions

Providers may not employ or sub-contract direct care personnel who are an immediate family Member of the Member served to work in the setting in which the Member is served.

- 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 Member as contained in the work/learn action plan and incorporated into the CCP to achieve their outcomes and goals;
  - Employ job-coaching techniques and to help the Member 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 fade paid supports in response to increased natural supports;
  - Identify specific information about the Member's interests, preferences and abilities;
  - Effectively communicate with the employer about how to support the Member to succeed in their employment, 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 documentation that demonstrates this information was 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 work/learn action plan/CCP that require intensive one-on-one staff support;
- Communicate effectively with the Member including communication through the use of adaptive equipment if applicable, at the work site;
- Document information that pertains to the CCP, progress notes, outcomes, and health and safety issues/concerns and any and all other required documentation by HCA/MAD;
- Adhere to relevant state policies/standards and provider policies and procedures that directly impact services to the Member;
- Model behavior, instruct and monitor any workplace requirements to the Member;
- Adhere to professionally acceptable business attire and appearance, and interact and communicate through a business-like, respectful manner; and
- Adherence to the rules of the specific workplace, including dress, confidentiality, safety rules, and other areas required by the employer.

Supervision

- In a group employment setting (a setting where up to six individuals work in an integrated setting with staff supports on site), the Employment Supports provider determines the job site and is responsible for the day-to-day supervision of the members and for follow-up services. For individual placements, the employer is responsible for the provision of general supervision consistent with the role as employer. When necessary and appropriate, the Employment Support provider may supplement these services.

Reimbursement

Employment Supports providers 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 basis 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: incentive payments made to an employer to encourage or subsidize the employer's participation in an employment supports program, payments that are passed through to users of employment supports programs, or payments for training that are not directly related to a Member's employment supports program. Federal financial participation cannot be claimed to defray expenses associated with starting up or operating a business.

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 CCP. 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, air conditioning, remodeling bare rooms, and other general household repairs.

Provider Requirements/Qualifications:

- The environmental modifications must be provided by an active, Medicaid approved provider type 363, environmental modifications provider.
- The environmental modification provider must comply with all New Mexico State laws, rules and regulations, including applicable building codes and the Construction Industries Licensing Act, NMSA 1978, Section 60-13-3.
- The environmental modification provider must maintain a 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 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 is responsible for all adaptions being made to Member's home, including but not limited to: oversight of construction and all administrative and technical oversight of projects.
- The environmental modification provider must provide consultation to family members, waiver providers and MCOs concerning environmental modification projects to the Member's residence and complete a final inspection of the environmental modification project to ensure that the adaptations meet the approved plan submitted for environmental adaptation. The MCO Care Coordinator will also complete a final inspection to ensure the environmental modification provider has completed the project according to authorization before final payment is made to the environmental modification provider.
- Environmental modification providers who receive authorization from an MCO for a Member project must complete the authorized job and retain full control of the authorized project. Portions of the authorized project may be contracted out; however, the environmental modification provider retains full responsibility for the entire project.
- 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 Care Coordinator, after the completion of work:
  - Letter of approval of work completed signed by the Member; and
  - Photographs of the completed modifications.
- The MCO must submit the Care Coordinator Individual Assessment of Need to the provider.

Reimbursement

Environmental modification provider agencies must maintain appropriate record keeping of services provided, and fiscal accountability as indicated in the Medicaid PPA. Billing is based on a project basis, one unit per environmental modification project. Reimbursement for environmental modification services will be based on the authorized environmental modification project 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 $6,000.00 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.

8.12. Home Delivered Meals

Medically Tailored Meals (MTM), provided for Agency Based Community Benefit members living in the community, up to two meals per day, provided as specified in the comprehensive care plan. Meals are medically tailored and based on the member's preferences.

Scope of Services/Requirements:

Turquoise Care members in Care Coordination Level 2 (CCL2) who meet a Nursing Facility Level of Care (NF LOC) and receive Agency-Based Community Benefit (ABCB) services may be eligible based on their comprehensive needs assessment (CNA).

Provider Requirements:

- Must be enrolled in New Mexico Medicaid as Provider Type 363 Community Benefit with specialty type 330.
- Must have knowledge of principles, methods, and procedures of the covered nutrition interventions meant to support an individual in obtaining food security and meeting their nutritional needs.
- Must be able to receive referrals from Turquoise Care MCOs.
- Must be able to deliver to the member's residence or other appropriate location, including last mile delivery, and track and report on service delivery (including unsuccessful deliveries).
- Must comply, during all stages of food service operation, with applicable federal, state and local regulations, codes, and licensor requirements relating to fire; health; sanitation; safety; building and other provisions relating to the public health, safety, and welfare of individuals receiving CB MTMs.
- Must follow best practice guidelines and industry standards for food safety. This includes meals remaining at safe temperatures, hot or cold, during transit and delivery.
- Must include a Registered Dietician or Registered Dietician Nutritionist or other comparable professional to develop the nutritional content of the CB MTMs.

- Must ensure that any employee or volunteer who delivers CB MTMs to a member's home has passed a background check, or the provider must use a delivery service such as U.S. Mail.
- Must not solicit payment or donations from any Medicaid member or their families/representatives.
- The provider will survey/connect with members on regular intervals to ensure quality of food and address any concerns.
- Meals must be medically tailored to a variety of diets and member preferences; however, the provider is not required to cater to all preferences and diets.
- Offering meals which cater to cultural and religious preferences are preferred but not required.

Billing and Reimbursement:

Procedure Code: CB Providers with provider type 363 and specialty type 330 will bill procedure code S5170.

Units: One meal is one unit. Two units are allowed per day.

Reimbursement: MCOs should reimburse providers at a minimum of $8.00 per home delivered meal.

Covered Services and limitations:

- Medically tailored home delivered meals are provided on a regularly scheduled basis, for one or more days per week, or as specified in the comprehensive care plan (CCP), in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the member. Services are furnished consistent with the member's person-centered care plan.
- Meals provided as part of this service shall not constitute a "full nutritional regimen" (3 meals per day).
- The receipt of MTM may reduce, but not replace, needed Personal Care Hours allotted for meal preparation. For example, MCOs must allow time for defrosting and heating meals as needed to ensure that members are able to consume CB MTMs.
- MTMs are not provided to CB members who reside in a licensed assisted living facility (ALF) or other location where a full nutritional regimen is provided.
- MTMs may be provided to members who receive adult day health (ADH) services, if MTMs are not provided at the licensed ADH facility.

- MTMs may not be provided if the member already receives full medically tailored nutritional support from another program.

Managed Care Organization Requirements:

- As with other CB services, MCOs must develop provider training and contracting information and provide network support for CB MTM providers.
- CB MTM providers will be audited annually with other CB providers.
- MCOs must develop and widely disseminate information to members and community stakeholders regarding access to the CB MTM benefit.
- MCOs must collaborate with Community Based Organizations (CBOs) to develop infrastructure that will eliminate barriers to becoming a CB MTM provider and to increase utilization of regional vendors and food producers.
- MCOs must implement oversight, monitoring and measures to ensure that CB MTMs are meeting generally accepted dietary guidelines for the member's condition(s).
- MCOs will ensure that care coordinators are trained to discuss CB MTMs with members by using, at a minimum, the following questions to prompt conversation. MCOs may develop additional questions as needed:
    1. Do you ever find yourself without enough money to buy the food you need, or face challenges in accessing healthy food due to factors such as availability or transportation?
    2. Do you have any dental, oral, or other medical conditions that make eating or swallowing difficult?
    3. Has a healthcare professional recommended that you change your diet due to a condition or illness, leaving you unsure about which foods are considered healthy?
    4. Do physical limitations make it challenging for you to prepare and consume healthy meals, shop for groceries, cook, or feed yourself?
    5. Have you had any unintended weight loss in the past 6 months?
    6. Are you able to store frozen or refrigerated meals until you are ready to eat them?
- MCOs will ensure member education includes:
    - Delivery method for receipt of meals,
    - Number of meals member will receive in each delivery and how many days/meals each delivery will cover,

- How to appropriately store meals, including how quickly meals must be stored once received, and space needed for storage,
- Member will need to make arrangements for any assistance needed in lifting meals box or putting meals away once received,
- Understanding how to contact the meal provider if any issues arise and how meal provider might contact member.

8.13. Home Health Aide (HH 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/Requirements:

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 within the ABCB are provided hourly, for eligible ABCB members who need this service on a long-term basis. HH Aides may provide basic noninvasive nursing assistant skills within the scope of their practice. HH Aides perform procedures as an extension of nursing and therapy services such as; bowel and bladder care, ostomy site care, personal care, walking 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.

All supervisory visits/contacts must be documented in the Member’s HH Aide clinical file on a standardized form that reflects the following:

- Service received;
- Member’s status;
- Contact with family members; and

- Review of HH Aide PCCP with appropriate modification annually and as needed.

Provider Requirements/Qualifications:

- HH Aide services must be provided by an active, Medicaid approved provider type 363, Home Health Agency (HHA);
- The HHA must maintain (no gaps in license) full permanent license by the New Mexico Licensing and Certification Bureau, Division of Health Improvement; DOH as an HHA;
- In order to be approved and certified by the HCA/MAD/LTSSB, the HHA must be holding and operating with a fully approved permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete packet is submitted;
- The HHA provider must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.
- The HHA nursing supervisor(s) must have at least one year of supervisory experience. The nursing supervisor will supervise the RN, LPN and HH Aide;
- The HHA staff will be culturally sensitive to the needs and preferences of members 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 CCP to the MCO Care Coordinator;
- All physician orders that change the Member's service needs must be conveyed to the MCO Care Coordinator for coordination with service providers and modification to CCP if necessary;
    - The HHA will document in the Member's clinical file that the supervision of the HH Aide 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 nursing supervisor, 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.

- **Qualifications for employed HH Aides:**
  - 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;
  - HH Aide training at the licensed HHA which follows the Federal HH Aide training regulation in 42 CFR 484.36 or the State Regulation 7 NMAC 28.2;
  - A CNA must have successfully completed the employing HH Agency's written and practical competency standards and have met the qualifications for a HH Aide. Documentation will be maintained in personnel file;
  - A HH Aide who was not trained at the employing HHA must successfully complete the employing HHA's written and practical competency standards before providing direct care services to an ABCB Member. Documentation will be maintained in personnel file; or
  - The HH Aide will be supervised by the HH Agency nursing supervisor or designee at least once every two weeks in the Member's home; and
  - The HH Aide will be culturally sensitive to the needs and preferences of the members and their families. Based upon the individual language needs or preferences, the HH Aide may be requested to communicate in a language other than English.

Reimbursement

The HHA must maintain appropriate record keeping of services provided by personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly basis 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. HHAs have the responsibility to review and ensure 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.

8.14. Nutritional Counseling

Nutritional Counseling services are designed to meet the unique food and nutritional needs of ABCB members. These services are available to assist members living in a community setting to maintain (or

improve and maintain) their health and/or functional status and remain in their setting of choice. This does not include oral--motor skill development services, such as those provided by a speech pathologist. Nutritional assessment is defined as the evaluation of the nutritional needs of the ABCB Member based upon appropriate biochemical, anthropometric, physical and dietary data to determine nutrient needs and includes recommending appropriate nutritional intake.

Nutritional counseling is defined as advising and helping an ABCB Member obtain appropriate nutritional intake by integrating information from the nutritional assessment with information on food, other sources of nutrients, and meal preparation consistent with cultural background and socioeconomic status.

Nutritional Counseling services may be in addition to and cannot duplicate nutritional or dietary services allowed in the Member's Medicaid state plan benefit, or another funding source.

Scope of Services/Requirements:

Services can be initiated where they are indicated and authorized in the Member's PCCP/CCP. A PCCP will be developed by the Nutritional Counseling provider with identified goals and measurable objectives and will be attached to or incorporated into the CCP. The MCO should agree to the arrangements for record-keeping, and the frequency and duration of services with the provider agency or individual provider.

Nutritional Counseling services include:

- 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.

The services allow for consultation with appropriate professionals, attendance at/participation in Interdisciplinary Team meetings, liaison with the Member's representative/family/caregivers, and monitoring of the nutritional plan.

Services are person-centered and must be culturally sensitive to the needs and preferences of the Member and their household based upon language and cultural traditions.

The staff: client ratio is 1:1 with the Member and/or the Member's representative for the period of time in which the Member is receiving Nutritional Counseling services. All services should be provided face-to-face. They may be provided at the Member's residence or an appropriate community location.

Agency Provider Requirements/Qualifications:

- Nutritional counseling services must be provided by an active, Medicaid approved provider type 363 Nutritional Counseling provider.
- The agency must have on staff or employ a full-time licensed dietitian or a licensed nutritionist who maintains (no gaps in licensure) a full permanent license through the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. Provisional permits are not acceptable.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nutritional Counseling providers must be operating with a fully approved permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Licensed nutrition associates will work under the supervision of a licensed dietitian or licensed nutritionist. The provider agency must ensure that the supervision requirements for licensed nutrition associates specified in the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. are met.
- All licensed practitioners providing nutritional assessment and counseling services will operate within their professional scope of practice.
- Provider agencies must comply with the HCA/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background checks, Labor Laws, etc.
- Provider personnel 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.
- Provider agencies must employ and maintain a sufficient pool of appropriately licensed and trained personnel to provide scheduled services to all ABCB members.

Individual Provider Requirements/Qualifications:

- Nutritional counseling services must be provided by an active, eligible, Medicaid approved provider type 363 Nutritional Counseling provider.

- The individual must maintain a full permanent dietitian license or a nutritionist license (no gaps in licensure) through the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et. seq. Provisional licenses are not acceptable.
- The individual may employ licensed nutrition associates who work under their supervision as a licensed dietitian or licensed nutritionist. The provider must ensure that the supervision requirements for licensed nutrition associates specified in the New Mexico Regulation and Licensing Department; Nutrition and Dietetics Practice Act, NMSA 1978, Section 61-7A et.seq. are met.
- All licensed practitioners providing nutritional assessment and counseling services will operate within their professional scope of practice.
- The individual provider must comply with HCA/MAD requirements including but not limited to: OSHA training requirements, Incident Management reporting, Criminal Background checks, Labor Laws, etc.
- All personnel 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.
- The individual provider must employ and maintain a sufficient pool of appropriately licensed and trained personnel, sufficient to provide scheduled services to all ABCB members on their caseload.
- Nutritional Counseling services must abide by all federal, state, HCA policies and procedures regarding billable and non-billable items.

Reimbursement

Nutritional Counseling provider agencies and individual providers must maintain appropriate record-keeping of services provided, personnel and training documentation, and fiscal accountability as indicated in the Medicaid Provider Participation Agreement (PPA). All services must be reflected on a PCCP that is coordinated by the Care Coordinator and authorized by the MCO. Reimbursement for Nutritional Counseling services will be based on the negotiated rate with the MCO. Billing is on an hourly basis and is accrued and rounded to the nearest quarter of an hour. Payment for Nutritional

Counseling services through the MCO is considered payment in full. Providers of service have the responsibility to review the prior authorizations issued from the MCO to ensure that the information on the prior authorization for their service is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

Billable Nutritional Counseling services include:

- Attendance and/or telephone conference calls to participate in Interdisciplinary Team meetings; and
- Training on Member-specific issues is included in the negotiated rate.

Limits or Exclusions

HCA does not consider the following to be Nutritional Counseling services and will not authorize payment for the following non-billable activities:

- General training requirements are an administrative cost and not billable;
- 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.

Nutritional Counseling 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 Community Benefit services are delivered.

8.15. Personal Care Services (PCS)

Scope of Services

PCS have been established by HCA/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 HCA 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. Approved PCS providers will complete the required EVV system training within 30 days of contracting with the MCOs.

Members who wish to receive fewer PCS hours than initially authorized should inform their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA) and can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment. The request for a reduction in hours must be Member-driven. Reduction in hours should

not be considered if reduction request is due to provider agency inability to staff, provider agency or caregiver coercion, or due to dereliction of duties/ poor performance of the caregiver. Members must be informed of their right to request a new or additional caregiver or new provider when available. A Member's request for a reduction in hours should not be made for temporary or otherwise short-term periods. A Member must understand the request for reduced hours will be for the remainder of their budget/care plan year. However, if the Member has a change in condition, change to natural supports, or otherwise needs to increase their hours back to the original assessed number, they may work with their Care Coordinator to do so. Any reduction of underutilization of PCS hours shall not be used as justification to reduce any future assessment of services needed by the Member.

Eligible Population

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

- 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 the 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 HCA pursuant to 8.352.2 NMAC, Recipient Hearings.
- 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, 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 their own service care delivery and requires that the consumer work with a PCS agency acting as a fiscal intermediary agency to process all financial and taxes paperwork.. Under this model, the agency acting as a fiscal intermediary can bill for a monthly administrative fee.

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;
- 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 their 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 their 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 their attendant and ensure all relevant employment paperwork and other applicable paperwork is completed and submitted; this may include, but is not limited to: employment application, verification from the employee abuse registry, criminal history screening, doctor's release to work, photo identification, proof of eligibility to work in the United States, copy of a State driver's license and proof of insurance;
- 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 their 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 they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS they will be immediately terminated; a copy of the signed agreement must be provided to the PCS;

- Ensuring if the attendant is the consumer's legal representative or legally responsible individual 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 or legally responsible individual 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, 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.

- 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 they are also a legal representative, but may assist the consumer in communicating, as appropriate. A personal representative may not be a personal care attendant, unless they are 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 approval: A PCS agency providing either the consumer directed, the consumer delegated, or both models, must comply with the requirements of this section. A PCS agency may only serve members in the counties that are approved by HCA. An agency listing, by county, is maintained by HCA/MAD or its designee. All Medicaid approved PCS agencies are required to select a county in which to establish and maintain an official office for conducting business with a published phone number and hours of operation; home offices are acceptable as long as they meet these requirements. The PCS agency must provide services in all areas of the county in which the main office is located. Upon HCA approval, the PCS agency may elect to serve any county within 100 miles of the main office. Proof of service areas being within 100 miles when driving may be required. The PCS agency must provide PCS services to all areas of all selected counties. The PCS agency may establish multiple offices within the state as long as each office meets the outlined requirements and is approved by HCA/MAD/LTSSB.. Proof of an established business license for the city/county of the office(s) may be required..
- To be certified by Medicaid or its designee, agencies must meet the following conditions and submit for approval, a packet, to Medicaid's fiscal agent or its designee, containing the following:
  - A 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 HCA 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;
  - 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; 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 approved 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, halfsiblings, grandchildren or grandparents (second degree by blood and uncles, aunts, nephews, nieces, great grandparents, and great grandchildren (third degree by blood); stepmother, stepfather, mother-in-law, father-in-law (first degree by marriage); stepbrother, stepsister, brothers-in-law, sisters-in-law, step grandchildren, grandparents (second degree by marriage); step-uncles, step-aunts, step-nephews, step-nieces, step-great grandparents, step-great grandchildren (third degree by marriage); 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;
  - 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 they cannot authorize employment for their 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 they are not eligible for PCS services;
  - Using the HCA 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;
- 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 29172 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 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 their own care or is noncompliant 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

o 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

- 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.

o Informing the consumer and their attendant of the responsibilities of the agency;

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

o Providing an informed consent form to consumers if the agency chooses not to provide transportation services as part of support services;

o 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

o 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:

▪ 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 their legal representative a signed agreement in which the attendant agrees that they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS they 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, 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;
- Encouraging the care giver to complete mental health first aid training and providing information on where the training can be obtained;
- 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 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 their 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;
    - 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 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;
- 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 they will not provide PCS while under the influence of drugs or alcohol and acknowledges that if they are under the influence of drugs or alcohol while providing PCS, they will be immediately terminated;
- Ensuring, if the consumer has elected the consumer's legal representative as their 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;
  - 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;
  - If an in-person supervisory visit will negatively impact a Member's health or safety, a Member can request supervisory visits be done via video conference. These requests must be made to and approved by the Member's MCO. The MCO must verify that:
    - The Member's healthcare provider/doctor provided written request for the waiver of in-person visits,
    - The supervisory visit can be made via a video visit on their preferred platform,
    - The PCS provider has a process/policy in place to assure supervisory visit requirements can be fulfilled via a video visit.
    - The request is for no longer than six months. If the in-person visit must be waived for a longer period, the request must be renewed.
- 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 277A1 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);
- 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 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 they have signed their 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 they 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 they are under the influence of drugs or alcohol while providing PCS they will be immediately terminated;
- May not be the consumer's representative, unless they are also the legal representative;
- If the attendant is a Member of the consumer's family, they 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, they 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, and first aid training within the first three months of employment, and the attendant must maintain certification throughout the entire duration of providing PCS; additional training will be based on the consumer's needs as listed in the IPoC; attendants 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 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 ALF, 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 ALF, 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, they will be reassessed for services that were allocated between multiple consumers in a shared household; or

  - Such that they begin sharing a living space with another consumer(s), all consumers in the new shared living space will be reassessed 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.
  - General qualifications for Legally Responsible Individuals (LRI) 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 ABCB covered services under extraordinary circumstances in order to assure the health and welfare of the Member, to avoid institutionalization and provided that the state is eligible to receive Federal financial participation;
- Extraordinary circumstances include the inability of the agency 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 ABCB care plan. The request must include documentation showing all attempts to employ other available resources in the Member's community, the challenges the Member and/or providers encountered, and why the Member chosen providers were unable to successfully provide the approved covered service as approved in the ABCB 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 an LRI must be submitted in writing to the MCO by the provider. The request must be approved or denied in writing by the appropriate MCO/UR staff Member. The approval of an LRI must be renewed annually, at the same time as the NF LOC.

- 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 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; and/or
  - The consumer requests and interim assessment.

- 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
- 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.

  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 consumers' 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 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.

- Members who wish to receive fewer PCS hours than initially authorized would discuss with their PCS provider and Care Coordinator. The Member and Care Coordinator will work together to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA). In this agreement, they would specify the reduced number of hours they require and any additional comments about the reduction. Subsequently, both the agency and the Member can collaboratively revise the Member's Individual Plan of Care (IPoC) to reflect this reduced hour commitment. PCS are to be delivered only in the State of New Mexico. However, consumers who require PCS out of the state 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;
  - 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 they are 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 HCA 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 their MCO. Transfers may only be initiated by the consumer, their legal representative, or by a PCS agency on behalf of a consumer or their 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 their 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;
- 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 their 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 their 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 the 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;
- 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 their 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 their 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;
- The consumer has requested three or more transfers within a six-month period;
- The consumer wants their legal guardian or attorney-in-fact to be their attendant;
- The consumer wants an individual to be their 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 they must exhaust the grievance and appeal process with the MCO before a fair hearing can be filed with HCA 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:
  - 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 HCA 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 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

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's 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;
    - 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.
- Advertising for the purpose of hiring caregivers/employees is not prohibited and does not require prior approval from Medicaid.

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.

8.16. Private Duty Nursing (PDN) for Adults

PDN 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 PDN require the skills of a licensed RN or an LPN under a written physician's order in accordance with the New Mexico Nurse Practice Act, Code of Federal Regulation for Skilled Nursing. PDN services are planned in collaboration with the physician, the Member, and the MCO Care Coordinator. All services provided under PDN are pursuant to a physician's order and in conjunction with the MCO. The private duty nurse will develop and implement a PCCP/Treatment (CMS form 485) that is separate from the CCP developed by the MCO. Members do not have to be homebound in order to receive this service. PDN and Medicare/Medicaid skilled nursing may not be provided at the same time. PDN services offered through the ABCB program will vary in scope and duration from Medicare and Medicaid skilled nursing. PDN 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 PDN provider and shared with the MCO Care Coordinator. Children (individuals under the age of 21) receive this service through the EPSDT.

PDN services are provided with the understanding that the MCO is the payer of last resort. PDN 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.

Scope of Services/Requirements:

Specific services may include the following:

- Obtaining pertinent medical history;
- Observing and assessing the Member's condition;
- Administration of medications including: oral, parenteral, gastrostomy, jejunostomy, inhalation, rectal and topical routes;
- Providing wound care, suture removal and dressing changes;
- Monitoring feeding tubes (i.e., gastrostomy, nasogastric, or jejunostomy including patency), including signs of possible infection;
- Monitoring bladder program and providing care, including ostomy and indwelling catheter insertion and removal;
- 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;
- Developing the PCCP/treatment 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 PCCP/treatment (CMS form 485) on the basis of the Member assessment and evaluation;
- Analyzing and interpreting Member's needs on the basis of medical history, pertinent precautions, limitations, and evaluative findings;
- Developing interventions to assist the Member to achieve and promote health to meet the Member's needs;
- Developing individualized service goals, identifying short and long-term goals that are measurable and objective; and/or
- Documenting dates and types of treatments performed, as well as Member's response to treatment and progress toward all goals.

Requirements include the following:

- 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;
- PDN services listed in the PCCP are to be within the scope of the New Mexico Nurse Practice Act, are provided subsequent to obtaining a physician's order and 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 PDN service and annually with the PCCP renewal, if PDN are to continue.

- The PDN supervisor will provide clinical supervision in the Member's home at a minimum of once each quarter. Supervision of PDN services must be documented in the Member's clinical record;
- 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 PDN services, and will be shared with the MCO Care Coordinator;
- The PCCP/Treatment (Form CMS-485) will be provided to the MCO Care Coordinator. 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 PDN in accordance with the Care Plan. The provider agency will provide the MCO Care Coordinator 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 PCCP/Treatment;
- Reports must be current and available upon request of HCA/MAD;
- Reviewing and revising the PDN PCCP/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 CCP;
- 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; and
- Providing Member and/or caregiver education regarding services. Document the date and time this occurred in the Member's clinical file.

Provider Requirements/Qualifications:

- PDN services must be provided by an active, Medicaid approved provider type 363, PDN provider;
- PDN providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing;

- PDN services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363, PDN provider;
- PDN providers must comply with provision of the Nurse Practice Act and all city, state and federal rules/regulations;
- In order to be approved and certified by the HCA/MAD LTSSB, PDN providers must be operating with a full permanent license. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted. Provisional licenses will not be accepted; and
- PDN providers must comply with all applicable State and Federal rules and regulations under the Nurse Practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.

Staffing Requirements:

- An RN or LPN is considered a qualified private duty nurse when the following criteria are met:
  - Must have current (no gaps in license) licensure as required by the state of New Mexico; provisional licenses are not acceptable;
  - 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 must 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.

Reimbursement

PDN providers are responsible for providing clinical documentation that identifies their 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 CCP that is coordinated with the Member/Member's 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 program. Billing is on an hourly basis and is accrued and rounded to the nearest quarter of an hour. Reimbursement for PDN for adults will be based on the negotiated rate with the MCO. 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 PDN services is through the MCO and is considered payment in full.
- PDN services must abide by all Federal, state, HCA, policies and procedures regarding billable and nonbillable items.
- PDN providers must ensure all insurance records are maintained correctly.
- Billable hours are as follows:
    - Face-to-face activities that are described above in the scope of service for PDN;
    - Attendance and/or telephone conference call to participant in IDT meetings;
    - Development of the PCCP/Treatment, not to exceed four hours annually; and
    - Training on Member specific issues is reimbursable and included in the negotiated rate; general training requirements are an administrative cost and not billable.

Limits or Exclusions

- HCA/MAD does not consider the following to be professional PDN services and will not authorize payment for the following nonbillable activities:
    - Performing specific errands for the Member 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.

8.17. 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 CCP. A primary caregiver is the individual who has been identified in the PCCP 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 nursing respite services. Nursing respite services may be provided in the Member's home, in the nursing respite provider's home, and in the community. Nursing respite services may be provided by an RN, or an LPN. Nursing respite services are limited to a total maximum of 300 hours per PCCP year. Nursing respite provider agencies will use the state mandated EVV system as required by the 21st Century Cures Act.

Scope of Services/Requirements:

Specific services may include the following:

- 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 PDN services, based on the Member's needs;
- Assistance with the enhancement of self-help skills;
- Assistance with providing opportunities for leisure, play and other recreational activities~~.~~;

Requirements include the following:

- Nursing Respite services are available to any Member of any age;
- Nursing Respite services are determined by the MCO Care Coordinator and documented on the CCP;
- Scheduling of hours for use of nursing respite services is the responsibility of the nursing respite provider and the Care Coordinator; and

- Nursing respite services provided by a PDN provider requires a physician's order that includes the scope and duration of service(s). A new physician's order will be obtained annually with the CCP renewal or when there is a revision in the service. The order must be obtained by the agency providing PDN and shared with the MCO Care Coordinator. 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.

Provider Requirements/Qualifications:

The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA/MAD to provide PDN services, as described in this section of the policy.

- Nursing respite services must be provided by an active, Medicaid approved provider type 363 Nursing Respite provider.
- Nursing respite providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing. Provisional licenses will not be accepted.
    - Nursing respite services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363 nursing respite provider.
- Nursing respite providers must comply with provisions of the Nurse Practice Act and the state rules/regulations.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nursing respite providers must be holding and operating with a full permanent license (no gaps in license). All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Nursing respite providers must comply with all applicable State and Federal rules and regulations under the nurse practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.;

- Nursing respite providers must have a functioning office located in New Mexico where staff and members can go to obtain information and/or assistance.
- The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA/MAD to provide PDN services, as described in this section of the policy.

Staffing Requirements:

- An RN or LPN is considered a qualified respite nurse when the following criteria are met:
  - Must be holding and maintaining a current (no gaps in licensure) permanent license 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;
  - RNs who supervise must have at least one year of supervisory experience. Supervision of RNs and LPNs must be provided by a qualified RN on a quarterly basis 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.

Supervision of nursing respite 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.

Nursing respite 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 CCP.

Reimbursement

Reimbursement is on an hourly basis and is accrued to the nearest quarter of an hour. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and not billable.

Reimbursement for nursing respite services will be based on the negotiated rate 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 must contact the MCO immediately to have the error corrected.

Limits or Exclusions

The Member cannot schedule their own nursing respite with the nursing respite staff. The Member may receive a maximum of 300 total hours of nursing respite hours annually per CCP year provided there is a primary caregiver. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

8.18. 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 an intermittent basis (i.e., daily or as needed). Respite services provide a temporary relief to the primary caregiver during times when they would normally provide unpaid care. If a caregiver needs a break during the time when they provide 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/or in the community. Respite services are limited to a total maximum of 300 hours per CCP year. Respite services does not cover or provide skilled care. If a Member requires skilled care, that care must be provided by a PDN or a nursing respite provider approved as a provider type 363, nursing respite provider. Respite services are provided pursuant to the CCP, developed and authorized by the Member and the MCO Care Coordinator. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

Scope of Services/Requirements:

Specific respite services may include the following:

- Household Activities – The following household activities are considered necessary to maintain a clean and safe environment and to support the Member 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 respite 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);
  - 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 provider:
  - 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 their physician, and are able to communicate their bowel care verbally or in writing. A physician must prescribe a bowel 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 they are 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 their 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 they are 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 only in accordance with the New Mexico Nursing Practice Act. Getting a glass of water or juice as requested if Member is not able to do that for himself/herself, handing the Member a daily medication box or medication bottle. For the Nurse Practice Act, refer to the PDN services in this policy;
- 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;
- 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 their 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;
- Accompanying or assisting with non-medical transportation~~.~~;
- Respite services are available to any Member of any age; and
- Respite services are determined by the MCO Care Coordinator and documented on the CCP.

Provider Requirements/Qualifications:

- Respite services must be provided by an active, Medicaid approved provider type 363 Respite provider.
- In order to be approved and certified by the HCA/MAD/LTSSB, respite providers must be able to demonstrate all requirements in this section are met. All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted;
- 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.

- Respite agencies may be licensed by the DOH as an HH agency pursuant to 7.28.2.1 NMAC et seq. and must meet all requirements in this section of the policy to be approved as a Medicaid provider type 363 respite provider;
- 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 HCA/MAD;
  - Respite agencies must ensure written notification to the MCO Care Coordinator and provide the MCO with a copy of the incident report.
- 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; and
- 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.

Reimbursement

Respite provider agencies must maintain appropriate record keeping of services provided to personnel and training documentation, and fiscal accountability as indicated in the Medicaid PPA. Billing is on an hourly basis 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 MCO. 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.

ABCB respite provider agencies will use the state-mandated EVV system as required by the 21st Century Cures Act. Approved ABCB respite providers will complete the required EVV system training within 30 days of contracting with the MCOs.

Limits or Exclusions

Respite services cannot be included in the CCP in combination with Assisted Living. 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. Respite providers do not provide skilled 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 may receive a maximum of 300 hours annually unless additional hours are approved by the MCO.

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.

8.19. Skilled Maintenance Therapies

Skilled maintenance therapies include Occupational Therapy (OT), Physical Therapy (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.

8.20. Occupational Therapy (OT) 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. The OT provider must develop a PCCP with the Member and share with the MCO Care Coordinator, which will be incorporated into the CCP. Children (under the age of 21) receive this service through EPSDT.

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.

Scope of Services/Requirements:

- Teaching daily living skills;
- Developing perceptional 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;
- Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up; and

- The occupational therapist must perform a comprehensive assessment evaluation for each Member to determine appropriate therapy, develop a PCCP and coordinate services with the MCO Care Coordinator. Services may include the following:
  - Obtaining pertinent medical history;
  - Assessing the Member for specific needs in gross/fine motor skills pertinent to OT;
  - Adapting the Member's environment in order to meet their 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/PCCP on the basis of the Member's 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/PCCP 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: client rate is 1:1 for the period of time in which a specific Member is receiving therapy services; and/or
- Occupational 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.

Provider Requirements/Qualifications:

- Occupational therapy services must be provided by an active, Medicaid approved provider type 363 Occupational therapy provider.
- Occupational therapists must comply with provisions of the Occupational Therapy Act and all other city, state and federal rules and regulations.
- Occupational therapists must maintain (no gaps in licensure) a full permanent Occupational therapist license from the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.
- In order to be approved and certified by the HCA/MAD/LTSSB, Occupational Therapists must operate with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- OT experience preferably in 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;
- Certified Occupational Therapy Assistants (COTA) may perform OT procedures and related tasks pursuant to a PCCP written by the supervising licensed occupational therapist. A COTA must be supervised by a licensed occupational therapist. All related tasks and procedures performed by a COTA must be within a COTA scope of service following all Federal and state requirements applicable to COTA services;

- Provider agencies must adhere to the HCA/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 Member;
- 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 Care Coordinator;
- Therapy reports must be current and available upon request of HCA/MAD; and
- OT providers must ensure all insurance records are maintained correctly in the Member's clinical file.
- The OT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

Reimbursement

Providers are responsible for providing clinical documentation that identifies their 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's representative, other caregivers as applicable, and authorized by the MCO. All services provided, claimed, and billed must have documented justification supporting medical necessity. Reimbursement is on a per hour basis and rounded to the nearest quarter hour.

- Payment for OT services is based on the negotiated rate through the MCO and is considered payment in full. 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 must contact the MCO immediately to have the error corrected.
- OT providers must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable 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;
- Training on Member specific issues is reimbursable, general training requirements are an administrative cost and not billable.

Limits or Exclusions

- HCA does not consider the following to be professional OT services and will not authorize payment for the following nonbillable activities:
  - Performing specific errands for the Member 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.

8.21. Physical Therapy (PT) 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. Children (under the age of 21) receive this service through EPSDT.

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.

Scope of Services/Requirements:

- 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 Member or Care Coordinator;
- Using of equipment and technologies or any other aspect of the Member's PT services;
- Training regarding PT activities;
- Training of all relevant staff, family, primary caregiver, etc., in the implementation of the therapy plan and follow up.
- The physical therapist must perform a comprehensive assessment evaluation and develop a PCCP 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 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 their needs;
    - Evaluating, including the administration and interpreting tests and measurements within the scope of the therapist;
    - 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/PCCP 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; 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 ratio 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.

Provider Requirements/Qualifications:

- Physical therapy services must be provided by an active, Medicaid approved provider type 363 Physical therapist provider.
- Physical therapists must comply with all provisions and city, state and federal rules regarding physical therapy.
- Physical therapists must maintain (no gaps in licensure) a full permanent physical therapist license from the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.

- In order to be approved and certified by the HCA/MAD/LTSSB, Physical Therapists must be holding and operating with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- The PT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

- Staffing Requirements:
  - PT experience preferably in 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 Physical Therapy Assistants (PTA) may perform PT procedures and related tasks pursuant to a PCCP 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 HCA/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 HCA/MAD.

Reimbursement

Reimbursement for PT services will be based on the negotiated rate with the MCO. Providers of service have the responsibility to review and ensure that the information on the prior authorization for their

services is correct. If the provider identifies an error, they must contact the MCO immediately to have the error corrected.

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.

Each provider of PT services is responsible to provide clinical documentation that identifies their 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.

- PT services must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable items; and
- PT providers must ensure all insurance records are maintained correctly.

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;
    - Training on Member specific issues is reimbursable, general training requirements are an administrative cost and not billable;

Limits or Exclusions

- HCA does not consider the following to be professional PT services and will not authorize payment for the following nonbillable 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.

8.22. Speech Language Therapy (SLT) 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. Children (under age 21) receive this service through EPSDT.

SLT 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.

Scope of Services/Requirements:

Specific services may include the following:

- 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 their 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.
- 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.;
- 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.

Provider Requirements/Qualifications:

SLT services must be provided by an active, Medicaid approved provider type 363 SLT provider.

SLT providers must maintain (no gaps in licensure) a full permanent license by the New Mexico Regulation & Licensing Department. Provisional licenses will not be accepted.

In order to be approved and certified by the HCA/MAD/LTSSB, SLT providers must be operating with a fully approved permanent license. All incomplete applications submitted to HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.

- 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;
- SLT experience preferably in 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 HCA/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 Member;
  - 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 Care Coordinator; and
  - Therapy reports must be current and available upon request of HCA/MAD.
  - The SLT provider agency must have and maintain one or more functioning, physical office located in New Mexico, where staff and members can go to obtain information or assistance.

Reimbursement

- SLT providers are responsible for providing clinical documentation that identifies their 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. Reimbursement is on a per hour basis and rounded to the nearest quarter hour.

- Payment for SLT services is based on the negotiated rate through the MCO and is considered payment in full. 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 must contact the MCO immediately to have the error corrected.
- SLT services must abide by all Federal, State, HCA policies and procedures regarding billable and nonbillable 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.

Limits or Exclusions

- HCA/MAD does not consider the following to be professional SLT services and will not authorize payment for the following nonbillable 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 providers must ensure all insurance records are maintained correctly.

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 Delivered Meals	S5170	1 meal = 1 unit
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
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 minutes
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.
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.
Stipend PCS and Respite	G9006 U1	Month	The code for reimbursing an ABCB provider for the use of the caregiver's personal cell phone for clocking in an out of the EVV system. The caregiver will receive the full stipend amount set by the MCO.

Stipend PCS and Respite	G9006 U2	Month	The code for reimbursing an ABCB provider for the use of the caregiver's personal cell phone for clocking in and out of the EVV system. This code is used when the caregiver is providing PCS and/or Respite to two or more members from different MCOs.

9. Self-directed Community Benefits (SDCB)

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.

- Home and Community Based Services (HCBS) shall meet all requirements of the HCBS Final Rule for Settings including the following requirements: 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.

CMS will take the following factors into account when determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS form the broader community of individuals not receiving HCBS:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS. Opportunities as well as identified supports to provide access to and participation in the broader community, should be reflected in both the individuals' person-centered service plans and policies and practices of the setting in accordance with 42 CFR 441.301(c)(1)(3) and (4)(vi)(F), 42 CFR 441.530(a)(1)(vi)(F) and 441.540, and 42 CFR 441.710(a)(1)(vi)(F) and 441.725;

- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with the beneficiary's person-centered service plan.

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.

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.

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 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. **FOCoS*online*:** The web-based system used by the SDCB FMA for receiving and processing SDCB payment requests. The FOCoS*online* 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. **Health Care Authority (HCA):** Designated by CMS as the Medicaid administering agency in New Mexico. HCA is also responsible for operating the SDCB HCBS for populations that meet the NF LOC (disabled & elderly, brain injury, and AIDS).
8. **Legally Responsible Individual (LRI):** A person who has a duty under State law to care for another person. This category typically includes: the parent (biological or adoptive) of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a 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 CB 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 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.
13. **SDCB Budget:** The maximum budget allotment available to an eligible Member, determined by their 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 their 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 FOCoS*online* or other state approved 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. **Signature:** Signature of Member or Member's legal representative. If a Member is unable to sign and does not have a legal representative, a thumbprint or personal mark (i.e., an "X") will suffice. Wherever signature is required, verified electronic signature may be used.
17. **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 an MCO.
18. **Verified Electronic Signature:** A verified electronic signature is an electronic signature that has been confirmed to be authentic and has not been tampered with. There are multiple ways to verify an electronic signature, including, but not limited to, Digital Certificates, Passwords, and Two-Factor Authentication.

9.5. SDCB Member Rights

SDCB Member has the right to:

- Decide where and with whom to live;
- Choose their own work or productive activity;
- Choose how to establish community and personal relationships;
- Make decisions regarding their 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.

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 their 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;
- 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 nonthreatening 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 their employees and vendors. A Member may be their own EOR unless the Member is a minor or has a guardianship or conservatorship in place that precludes the individual from exercising control over financial matters. 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 their 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 their own EOR, and based on the results of the self-assessment, the Care Coordinator determines that the Member requires assistance to direct their services, the Care Coordinator shall inform the Member that they 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 FMA. 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 and respite providers use the State approved EVV system as required. An EOR cannot be paid for any services utilized- by the Member for whom they are 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 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;
- Reviewing and approving/denying 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;
- Ensuring 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 their SDCB employees;
- Working 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;
- Meeting Federal requirements by using the state EVV system to document PCS and Respite services; and
- When necessary, requesting assistance from the Support Broker and/or Care Coordinator with any of these SDCB responsibilities.

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 Utilization Management (UM) duties, including review and approval or denial of each individual care plan. All SDCB members have an

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, 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;
- 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, elopement/missing and death;
- Monitoring the 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.

Support Broker services help the SDCB Member to identify supports, services and related goods that meet their 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;
  - Urgent care plan revisions must be made within three (3) business days of the EOR/Member's request. Updates are required to be made in the FMA system and the Member's Managed Care Organization must be notified of the update. 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;
- Assist in completing all documentation required by the FMA; and
- Assist with EVV functions including device registration and entering location information.

- 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:
  - 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 FOCoS*online* system; and to obtain information on the FMA;
- Discuss and review the EVV system that personal care and respite 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 the 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 their 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 their 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;
- Assist members to identify and resolve issues related to the implementation of the SDCB care plan; and

- Assist the Member, employee(s) and EOR in utilizing the EVV system, including but not limited to:
    - Registering the device (tablet, computer or mobile device) to be utilized for EVV;
    - Collaborating with MCO Care Coordination and the Member/EOR to resolve any time entry, timecard, or payment issues;
    - Understanding and agreeing to all roles and responsibilities of the EVV system;
    - Training and assisting Member/EOR and employee(s) on the EVV system to include:
        - Employee and EOR device enrollment
        - Employee initial log in
        - Employer Web log in
        - Alternate Interactive Voice Response (IVR) phone numbers
        - Updating alternate care locations

- 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 FOCoS*online* system. The care plan in FOCoS*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 FOCoS*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:

- 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 apply to the MCO personnel.

The Support Broker agency shall comply with all applicable Federal and 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 of 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;
- Ensure all employees are trained and competent in the use of the FMA and FOCoS*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 nonbusiness 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;
- 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 CNAs 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
    - Copies of completed EOR self-assessments.

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; and
- Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field; or
- Have one year of supervised experience working with seniors and/or people living with disabilities; or

- 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
- Pass a nationwide caregiver criminal history screening pursuant to NMSA 1978, Section 29172 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 277a1 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. 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, elopement/missing and Member deaths. This SDCB Member training shall also include reporting procedures for SDCB employees, members/Member representatives, and other designated individuals. Please refer to the Critical Incident Management Responsibilities for requirements.

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 29171 NMAC of the Caregivers Criminal History Screening Act and the National Sex Offender Registry;
- 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 their 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 HCA/MAD, as appropriate.
- Participate in an annual audit conducted by the MCOs.

FOCoS*online*

In addition to the above functions, the FMA operates FOCoS*online*. FOCoS*online* 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.

FOCoS*online* 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 FOCoS*online* 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 FOCoS*online*, as well as on-going technical assistance and help with problem solving.

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 their 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 their 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 FOCoS*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 their abilities, to direct the development of the SDCB care plan. If the Member desires, they 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 FOCoS*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 FOCoS*online*, the Member's SDCB care plan is ready for review and submission into FOCoS*online*. After reviewing the SDCB care plan, the Care Coordinator will submit it in FOCoS*online* to the MCO/UR for review and approval or denial using FOCoS*online*. Annual SDCB care plans shall be submitted by the Care Coordinator to the MCO/UR no later than 30 calendar days prior to the end of the current SDCB care plan/budget year. 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 FOCoS*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, 9.22.1);
- 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 FOCoS*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 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 the member 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.

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 29172 et seq. and 7.1.9 NMAC and an abuse registry screen pursuant to NMSA 1978, Section 277a1 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 their 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
- 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 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 an 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 an 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 (9.22.1) for the specific service the LRI is approved to provide and be approved by the MCO/UR.

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:
  - Inform and guide the SDCB Member, family, employees and/or vendors on 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 their 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 (master's or PhD level);
    - LISW or LMSW;
    - LPCC;

  - 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 (master's or PhD level);
    - LISW or LMSW;
    - LPCC;
    - LPC;
    - MSN/RNSC;
    - LMFT; or
    - LPAT.

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 noninstitutional and nonresidential settings.

- Customized community supports settings must be integrated and support full access of individuals receiving CB 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:
    - 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 their 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.

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 their choice in their community. The Member must exhaust all available vocational rehabilitation supports prior to requesting Employment Supports on their 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 Turquoise 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
  - 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 their 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;
- 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 workplace 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 workplace, 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;
- 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;
  - 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 their 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;
    - 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 their 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:
    - 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 their 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:
    - 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 their 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.

  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;
- 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.
- 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 environmental modification services will be based on the negotiated rate with the SDCB Member/EOR; Environmental modification services are limited to $6,000.00 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 $6,000.00, 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 $3,300.00 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 noninvasive 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.

- 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), they 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;
  - 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;
  - 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;
  - Rendering providers are 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;
    - 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;
  - 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 their 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 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);
- 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;
- 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
- 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.

- 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 their 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;
  - Cannot be provided to school age children during school hours; and
  - Respite must be documented through the EVV system.

- 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;
  - Complete Member specific training; the evaluation of training needs is determined by the Member or their 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 their 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 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.

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 CCP. A primary caregiver is the individual who has been identified in the PCCP 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 nursing respite services. Nursing respite services may be provided in the Member's home, in the nursing respite provider's home, and in the community. Nursing respite services may be provided by an RN, or an LPN. Nursing respite services are limited to a total maximum of 300 hours per PCCP year. Nursing respite services must not be provided by a Member of the Member's household or by any relative approved as the employed, paid caregiver. Nursing respite provider agencies will use the state mandated EVV system as required by the 21st Century Cures Act.

- **Scope of Services/Requirements:**
  - Specific services may include the following:
    - 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 PDN services, based on the Member's needs;
    - Assistance with the enhancement of self-help skills;
    - Assistance with providing opportunities for leisure, play and other recreational activities~~.~~;
  - Requirements include the following:
    - Nursing Respite services are available to any Member of any age;
    - Nursing Respite services are determined by the MCO Care Coordinator and documented on the CCP;
    - Scheduling of hours for use of nursing respite services is the responsibility of the nursing respite provider and the Care Coordinator; and
    - Nursing respite services provided by a PDN provider requires a physician's order that includes the scope and duration of service(s). A new physician's order will be

obtained annually with the CCP renewal or when there is a revision in the service. The order must be obtained by the agency providing PDN and shared with the MCO Care Coordinator. 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.

- **Provider Requirements/Qualifications:**

The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA~~SD~~/MAD to provide PDN services, as described in this section of the policy.

- Nursing respite services must be provided by an active, Medicaid approved provider type 363 Nursing Respite provider.
- Nursing respite providers must maintain (no gap in license) a full permanent license through the New Mexico Board of Nursing. Provisional licenses will not be accepted.
    - Nursing respite services may also be furnished through a licensed HH Agency, licensed RHC or certified FQHC who meet all requirements/qualifications in this section of the policy and are approved by the HCA/MAD/LTSSB as a provider type 363 nursing respite provider.
- Nursing respite providers must comply with provisions of the Nurse Practice Act and the state rules/regulations.
- In order to be approved and certified by the HCA/MAD/LTSSB, Nursing respite providers must be holding and operating with a full permanent license (no gaps in license). All incomplete applications submitted to the HCA/MAD/LTSSB shall be rejected and not considered for review until a complete application is submitted.
- Nursing respite providers must comply with all applicable State and Federal rules and regulations under the nurse practice Act and program standards determined by HCA/MAD including but not limited to CBCs, OSHA training requirements, incident management system reporting, labor laws, etc.;

- Nursing respite providers must have a functioning office located in New Mexico where staff and members can go to obtain information and/or assistance.
- The provider agency of nursing respite services must meet all requirements, certifications, and training standards set forth by the HCA~~SD~~/MAD to provide PDN services, as described in this section of the policy.

- **Staffing Requirements:**
  - An RN or LPN is considered a qualified respite nurse when the following criteria are met:
    - Must be holding and maintaining a current (no gaps in licensure) permanent license 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;
    - RNs who supervise must have at least one year of supervisory experience. Supervision of RNs and LPNs must be provided by a qualified RN on a quarterly basis 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.

Supervision of nursing respite 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.

Nursing respite 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 CCP.

- **Reimbursement**

  Reimbursement is on an hourly basis and is accrued to the nearest quarter of an hour. Training on Member specific issues is reimbursable and included in the negotiated rate, general training requirements are an administrative cost and not billable.

  Reimbursement for nursing respite services will be based on the negotiated rate 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 must contact the MCO immediately to have the error corrected.

- **Limits or Exclusions**

  The Member cannot schedule his or her own nursing respite with the nursing respite staff. The Member may receive a maximum of 300 total hours of nursing respite hours annually per CCP year provided there is a primary caregiver. Additional hours may be requested if an eligible Member's health and safety needs exceed the specified amount.

Self-directed Personal Care

- Definition of Service:

  Self-directed PCS are provided on a continuing basis to assist the Member with accomplishing tasks they would normally do for themselves if they 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
    - Attend trainings as designated by the Member in the care plan.
    - Must be provided as a one-on-one service; multiple members cannot receive services at the same time by one employee.
  - 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;
- Develop and adhere to QA rules and requirements; and
- Ensure all assigned staff meet the following qualifications. Documented proof of all requirements must be provided to Conduent upon request:
    - 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;
    - Each caregiver providing personal care services to a SDCB Member must 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. Self-Directed 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;
- 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 revision of services within the SDCB Care Plan must be requested 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 they are 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 HCA-approved LOC criteria; and
- The CNA

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 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.
  - 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;
    - 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:
  - 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, 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 reestablishing 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 rage of motion, decrease contractures and aid in normalizing muscle tone. Hippotherapy requires that the Member use cognitive functioning especially for sequencing and memory. Members with attention deficits and behavior problems are redirecting attention and behaviors by focusing on the activity. Hippotherapy involves therapeutic exercise, neuromuscular education, kinetic activities, therapeutic activities, sensory integration activities and individual speech therapy. The activities may also help improve respiratory function and assist with improved breathing and speech production. 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

- 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.
- 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;
    - 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:

  Startup goods are available to a Member who is transitioning from the ABCB to the SDCB for the first time. Startup goods are limited to one time. Startup goods help the Member in self-directing his or

her services. Examples of startup goods include, but are not limited to a computer, fax machine, and printer. All startup goods must be approved by the MCO. The cost and type of related good is subject to approval by the MCO. Startup goods must be purchased during the Member's first budget period. Startup 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 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;

  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;
- Complete training on critical incident, abuse, neglect, and exploitation reporting; and
- Possess and maintain current insurance policy and registration.

- Transportation Qualifications – Provider Agency:
  - 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;
    - 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.

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.

9.12. SDCB Budget and Care Plan Approval Process

The Care Coordinator adds the Member to FOCoS*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 they wish 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 FOCoS*online*.

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.

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 FOCoS*online* 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. 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 FOCoS*online*. 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 FOCoS*online*. 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.

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.

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 amounts 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 FOCoS*online*, with the begin and end dates for the upcoming SDCB Care Plan. Upon the annual SDCB budget determination, the Care Coordinator shall enter the SDCB budget amount in FOCoS*online*, allowing the Member and Support Broker to begin developing the upcoming year's Care Plan.

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 FOCoS*online* and a letter shall be sent to the Member including written instructions for the Member/legal representative to follow if the Member disagrees with the denial decision(s).

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 (9.22.1) 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.

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.

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 they disagree 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 FOCoS*online,* 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 FOCoS*online* 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 FOCoS*online*. 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 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 FOCoS*online,* 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.

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 (9.22.1) for that chosen service;
- 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.

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 Consolidated Customer Service Center at 1-800-283-4465.
    - 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 FOCoS*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 they have 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, they 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 they do 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

- 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
- 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:
    - SDCB employee (or EOR) must enter and approve the employee(s)'s timesheet(s) in FOCoS*online* unless they are approved for an exception to fax timesheets to the FMA. Upon completing the FOCoS*online* training, a new user will receive a FOCoS*online* Account Authorization form (via email). Once the new user completes the FOCoS*online* 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 FOCoS*online*. 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.

- Self-Directed Personal Care and Respite providers must utilize the EVV system to clock-in and out in order to generate a timesheet in FOCoSonline or other state approved system.

- 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 FOCoS*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 FOCoS*online*, they should review the payments and monitor them as they are being processed. In addition, the SDCB Member, EOR, or AR may run reports through FOCoS*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 signature
  - s, 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 FOCoS*online*) with a copy to the Care Coordinator

and Support Broker. If the EOR does not have an email address in FOCoS*online*, the FMA will send an email to the Care Coordinator and Support Broker and attach a copy of the RTM letter. Since frequent contact is attempted by the FMA to the EOR, it is extremely important that FOCoS*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 FOCoS*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 FOCoS*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 their approved SDCB care plan is spent appropriately; however, the Care Coordinator and Support Broker must support the SDCB Member in this activity. The FMA also assists in ensuring that

funds are spent appropriately through payment of approved services and related goods according to the approved SDCB care plan and Employee/Vendor Agreements;

- The Member/EOR is responsible for reviewing their 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 FOCoS*online*. It is highly recommended that members/EORs obtain access to FOCoS*online* so that they can effectively monitor their care plan/budget and track spending. Monthly training for FOCoS*online* 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 their 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 regard 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 nonpayment 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.

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 their SDCB provider(s) with 10 business days advance notice regarding their 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 their 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 their 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 their 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;
    - The SDCB Member expends their entire SDCB budget prior to the end of the SDCB Care Plan year;
    - The SDCB Member commits Medicaid fraud. The examples below are not all encompassing and only provide a few scenarios:
      - Altering SDCB employee/vendor payment checks
      - Cancelling gym membership and receiving cash back for the purchase

- Purchasing miscellaneous/unapproved items with funds received for approved goods

- 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 HCA 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 HCA 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 their MCO in writing. All members shall be required to participate in SDCB training prior to their reinstatement;
- A SDCB Member who voluntarily terminated their participation in SDCB may request to move back from ABCB to SDCB any time during a 12-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 12month 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.

9.22 Method of Payment for Goods and Services

- **Desired Method of Payment**

There are 3 options on the Vendor Payment Request form for the Desired Method of Payment that can be selected for members to purchase goods and pay vendors.

- Direct Deposit selection is for the funds to be deposited to the selected and approved Vendor
- Money Network selection is for the funds to be deposited into the EOR's Money Network Card and there after the EOR makes the payment to the vendor

- Paper Check selection is for the funds to be sent via a check made out to the Vendor through the mail and sent to the EOR to pay the vendor

- **Money Network Card**

The Money Network Card is an alternative option to pre-printed paper checks to pay for approved goods and services in stores and online that accepts credit or debit cards for payments.

- EORs may choose to continue to receive printed paper checks.
- The first time the Money Network Card is requested as the method of payment on the VPR the EOR will be mailed one Money Network Card.
- Money Network offers both card and check payments. An EOR will receive 3 checks when the card arrives. Additional checks can be ordered at any time free of charge.
- Any funds not used before the end of the budget year must be removed from the Money Network Card and be put back into the closing budget. NO Money Network Card funds can be transferred from one budget year to the next.

Proof of Purchase for Money Network Card

Conduent will conduct audits on purchases and may request receipts to verify approved items were purchased.

- EORs are required to keep proof of purchase (receipt, invoice, etc.) when using the Money Network Card or Check.
- EORs are required to respond to requests for documentation and information from Conduent, Support Broker, or their Care Coordinator.
- If there is no contact from the EOR/Member a sanction process will begin. Technical Assistance may be provided by the MCO to support the EOR/Member to be successful in providing the required proof of purchase when requested.

Money Network Card prohibited activity:

- Cash withdrawals
- ATM withdrawals
- Cash back from purchases
- Transferring Money Network Card funds to another bank

- Payment to self
- Payment to friends or family

SDCB EORs have certain responsibilities in order to utilize the Money Network Card. Failure to comply with these responsibilities can result in the EOR being disallowed from further use of the Money Network Card to purchase goods and services.

Approved SDCB Service Codes allowed for the Money Network Card

- T1999 – All Codes
- T028 – Start Up Goods and Services

The Money Network Card is also available to pay SDCB Employees-

Please visit the New Mexico - PALCO (palcofirst.com) website to download and complete the Pay Selection and Direct Deposit form found in the Self-Directed Community Benefit Documents section under Worker Forms.

-Under extraordinary circumstances a Member may qualify for an Electronic Timesheet Exception and complete a paper timesheet. The EOR must contact their Support Broker to discuss their Member options.

Link to Palco-paper invoice VPR

Please visit the New Mexico - PALCO (palcofirst.com) website to download the Vendor Payment Request form found in the Self-Directed Community Benefit Documents section under Vendor Forms.

9.23 Demand Notices

Employee Guidance for Demand Notices received from the New Mexico Department of Workforce Solutions:

- The New Mexico Department of Workforce Solutions (WFS) sends Demand Notices to Employees who do not send a quarterly wage report. The Demand Letter means the Employer of Record's, employee's Wage Detail Report for the quarter is due.
- Palco files these reports and makes any appropriate payments.

If a Demand Notice is received from WFS, have the employee send the letter to Conduent for Palco to review and follow up to ensure resolution via email, fax, or drop off.

9.24. Appendices

9.24.1 SDCB Range of Rates Chart

9.24.2 SDCB Vendor Credentialing Requirements

9.24.3 Employee Credentialing Requirements Grid

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- $17.20
HH Aide	S9122	S9122	Hour	$35.52
Employment Supports (includes Job Coach)	T2019	T2019	15 min.	$5.10
Job Developer (Per job that is developed for Member)	T2019	T2019JD	Each	$104.68-$732.76
Customized Community Supports (adult day hab.)	S5100	S5100	15 min.	$2.96-$9.35
PT	G0151	G0151	15 min.	$25.34-$49.66
OT	G0152	G0152	15 min.	$24.82-$40.83
Speech/Language Pathology	G0153	G0153	15 min.	$25.35-$48.93
Behavior Support Consultation	H2019	H2019	15 min.	$31.08
Private Duty Nursing – Adults- RN	T1002	T1002	15 min.	$29.76
Private Duty Nursing – Adults- LPN	T1003	T1003	15 min	$19.92
Nutritional Counseling	S9470	S9470	Hour	$88.88
Acupuncture	97810	97810	15 min.	$13.09-$26.17
Biofeedback	90901	90901	Visit	$52.34-$104.68
Chiropractic	98940	98940	Visit	$52.34-$104.68
Cognitive Rehabilitation Therapy	97532	97532	15 min.	$13.09-$26.17
Hippotherapy	S8940	S8940	Visit	$52.34-$104.68
Massage Therapy	97124	97124	15 min.	$15.66-$31.31
Naprapathy	S8990	S8990	Visit	$$52.34-$104.68
Respite Standard (not provided by RN, LPN or HHA)	T1005	T1005SD	15 min.	Minimum Wage (per hour) - $4.30
Respite RN	T1005	T1005RN	15 min.	$29.76
Respite LPN	T1005	T1005LPN	15 min.	$19.92
Respite HH Aide	T1005	T1005HHA	15 min.	$8.88
Emergency Response (monthly fee)	S5161	S5161	Each	$38.43-$42.70

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
Emergency Response (testing and maintenance)	S5160	S5160	Each	As approved by MCO
Environmental Modifications	S5165	S5165	Each	As approved by MCO (maximum of $6,000 every 5 years)
Transportation Mile	T2049	T2049	Per Mile	$0.36-$0.42
Transportation Commercial Carrier Pass	T2004	T2004	Each	As approved by MCO
Start Up Goods- Computer	T2028	T2028CR	Each	As approved by MCO
Start Up -Goods Fax Machine	T2028	T2028FX	Each	As approved by MCO
Start Up -Goods Internet Activation	T2028	T2028IA	Each	As approved by MCO
Start Up -Goods Landline Activation	T2028	T2028LA	Each	As approved by MCO
Start Up -Goods Office Supplies	T2028	T2028OS	Each	As approved by MCO
Start Up Goods Printer	T2028	T2028PR	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 Classes only (not available for paid caregivers)	T1999	T1999CL-I	Each	As approved by MCO
Coaching/education for parents, spouse or others Conferences and seminars (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

SDCB Service	Billing Code	Internal Focos Code	Unit	SDCB Payment Rate
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
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

9.22.2. SDCB Vendor Credentialing Requirements

Requirements for enrolling SDCB Vendors

Before using any Vendor, please call the Consolidated Customer Service Center (CCSC) at (1-800-283-4465) 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, Walmart, Kmart, 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 the CCSC 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 Allowed Providers: Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Acupuncture and/or oriental medicine license
H2019	Behavior Support Consultation Allowed Providers: 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 Allowed Providers: 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

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
98940	Chiropractic Allowed Providers: 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 Allowed Providers: Vendor	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1999CS-I	Coaching Education for Parents/Spouse: Conferences & Seminars ONLY Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CL-I	Coaching Education for Parents/Spouse: Classes ONLY Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
97532	Cognitive Rehabilitation Therapy Allowed Providers: Group practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: License in Health Care Profession whose scope of practice includes Cognitive Rehabilitation Therapy
S5100	Customized Community Support Allowed Providers: Adult Day Health Agency or Adult Day Habilitation Agency	Per 15 min	Agency: Yes	Agency: Business License
S5160	Emergency Response Testing and Maintenance Allowed Providers: Emergency Response Provider (Agency)	Each	Agency: No	Agency: Business License
S5161	Emergency Response Monthly Service Fee Allowed Providers: Emergency Response Provider (Agency)	Monthly	Agency: No	Agency: Business License
T2019	Employment Supports (includes Job Coach) Allowed Providers: Supported Employment Provider Agency or Individual	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
S5165	Environmental Modifications Allowed Providers: Individual or Company (Agency)	Each	Agency: Yes IC: Yes	Agency: Appropriate License IC: Appropriate License
T1999CP-I	Fees and Memberships Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)

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**
T1999HR-I	Health-Related Equipment and Supplies Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AE-I	Adaptive Equipment and Supplies Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999EE-I	Exercise Equipment and Related Items Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999NS-I	Nutritional Supplements Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999OM-I	OTC Medications Allowed Providers: Vendor	Each	Agency: No Yes IC: No	VIF is required (goods only)
S8940	Hippotherapy Allowed Providers: 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 Allowed Providers: HHA/PCS Agency	Hour	Agency: Yes	Agency: Business License
99509	Self-directed Personal Care Allowed Providers: Individual Self-directed Personal Care Provider or HHA/PCS Agency	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
T1999HG-I	Household Related Goods and Services Item/Invoice Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AI-I	Appliances for Independence Item/Invoice Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999AF-I	Adaptive Furniture Item/Invoice Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)

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
T2019JD	Job Developer Allowed Providers: Supported Employment Provider Agency or Individual	Each	Agency: Yes IC: Yes	Agency: Business License IC: Pre-Hire Packet
97124	Massage Therapy Allowed Providers: Group Practice or Individual Specialized Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: Massage Therapist License
S8990	Naprapathy Allowed Providers: Group Practice or Individual Specialized Therapist	Visit	Agency: Yes IC: Yes	Agency: Business License IC: Naprapathic Physician License
S9470	Nutritional Counseling Allowed Providers: Group Practice or Individual	Hourly	Agency: Yes IC: Yes	Agency: Business License IC: Registered Dietician License
G0152	Occupational Therapy Allowed Providers: Individual Occupational Therapist or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: OT License
G0151	Physical Therapy Allowed Providers: Group Practice or Individual Physical Therapist	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: PT License
T1003	Private Duty Nursing LPN Allowed Providers: HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1002	Private Duty Nursing RN Allowed Providers: HHA, RHC, FQHC or Individual	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T1005HHA	Respite Home Health Aide Allowed Providers: Respite Agency	Per 15 min	Agency: Yes	Agency: Business License

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
T1005SD	Respite Standard Allowed Providers: 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 Allowed Providers: Respite Provider Agency or Individual LPN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: LPN License
T1005RN	Respite RN Allowed Providers: Respite Provider Agency or Individual RN	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
G0153	Speech/Language Pathology Allowed Providers: Individual SLP or Group Practice	Per 15 min	Agency: Yes IC: Yes	Agency: Business License IC: RN License
T2028CR	Start-Up Goods- Computer Purchase Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T2028FX	Start-Up Goods - Fax Machine Purchase	Each	Agency: No IC: No	VIF is required (goods only)
T2028IA	Start-Up Goods - Internet Activation	Each	Agency: No IC: No	VIF is required (goods only)
T2028LA	Start-Up Goods - Landline Activation	Each	Agency: No IC: No	VIF is required (goods only)
T2028OS	Start-Up Goods – Office Supplies (purchased as items)	Each	Agency: No IC: No	VIF is required (goods only)
T2028PR	Start-Up Goods – Printer Purchase	Each	Agency: No IC: No	VIF is required (goods only)
T1999TS	Technology for Safety and Independence Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CR	Computer Purchase (item) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)

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
T1999PR	Printer Purchase (item) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999FX	Fax Machine Purchase (item) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CPEP	Cell Phone and Related Equipment Purchase (item) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IS	Internet Service Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CELL	Cell Phone Service Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999LS	Landline Service Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999ICL	Internet/Cell Phone/Landline Service (bundled) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IC	Internet/Cell Phone Service (bundled) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999IL	Internet/Landline Service (bundled) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999CPL	Cell Phone/Landline Service (bundled) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T1999OS	Office Supplies (purchased as items) Allowed Providers: Vendor	Each	Agency: No IC: No	VIF is required (goods only)
T2004	Transportation Commercial Carrier Pass Allowed Providers: Transportation Commercial Carrier	Each	Agency: No IC: No	VIF is required (goods only)
T2049	Transportation Mile Allowed Providers: 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 the Consolidated Customer Service Center (CCSC) at (1-800-283-4465) 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 the Consolidated Customer Service Center (CCSC) at 1-800-283-4465 or your Support Broker if you have any questions.

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

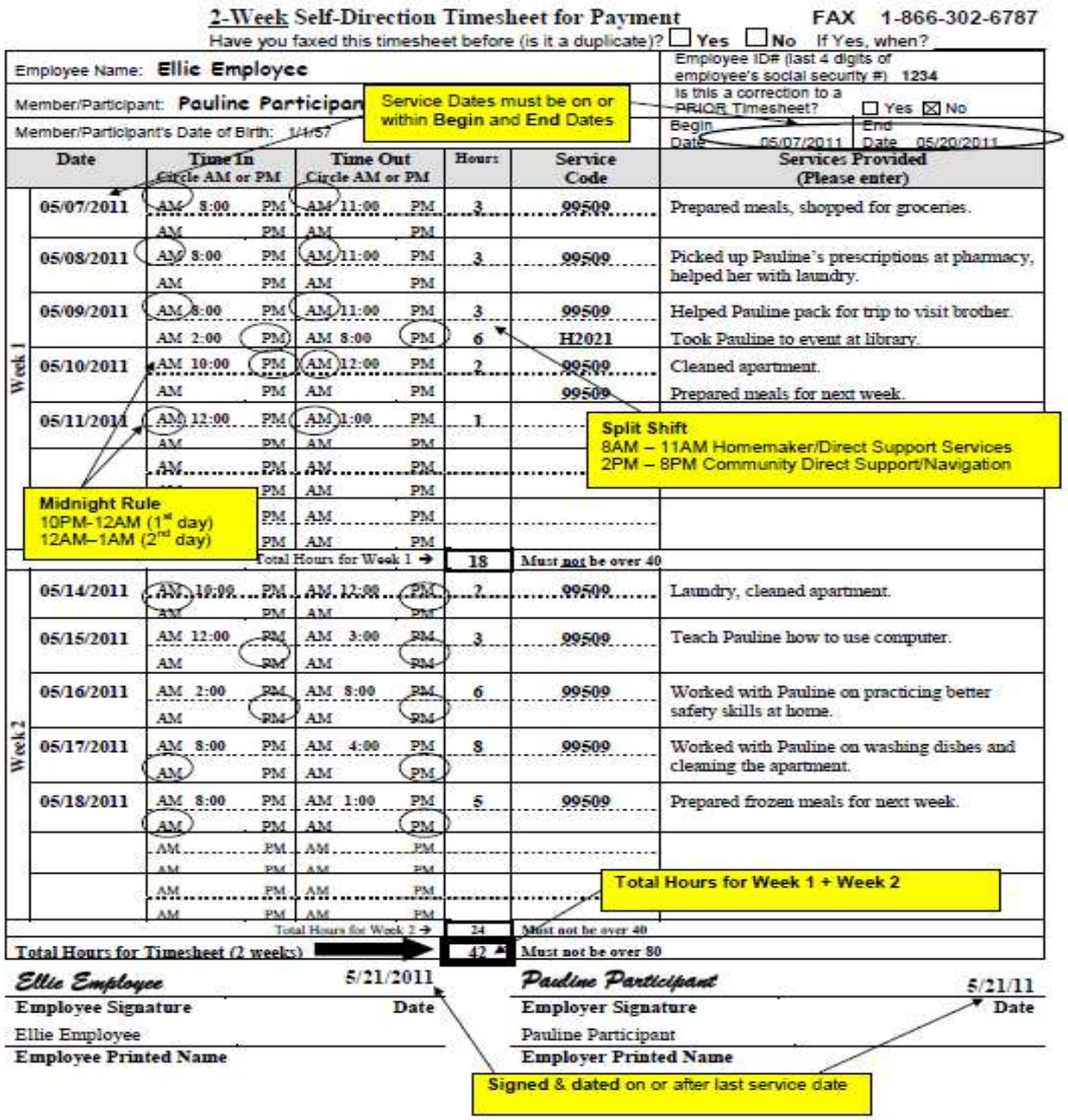
***Pre-Hire Packet:** Division of Health Improvement (DHI) form, copy of identification card, and three fingerprint cards.

****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 an Employee Agreement before the beginning of the new Plan, the employee may not get paid on time.

•



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 Participan** | Is this a correction to a PRIOR Timesheet? ☐ Yes ☒ No

Member/Participant's Date of Birth: 1/4/57 | Begin Date 05/07/2011 | End Date 05/20/2011

Service Dates must be on or within Begin and End Dates

	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	AM 11:00 PM	3	99509	Prepared meals, shopped for groceries.
	05/08/2011	AM 8:00 PM	AM 11:00 PM	3	99509	Picked up Pauline's prescriptions at pharmacy, helped her with laundry.
	05/09/2011	AM 8:00 PM	AM 11:00 PM	3	99509	Helped Pauline pack for trip to visit brother.
		AM 2:00 PM	AM 8:00 PM	6	H2021	Took Pauline to event at library.
	05/10/2011	AM 10:00 PM	AM 12:00 PM	2	99509	Cleaned apartment.
		AM PM	AM PM		99509	Prepared meals for next week.
	05/11/2011	AM 12:00 PM	AM 1:00 PM	1		
		AM PM	AM PM			
		AM PM	AM PM			
		PM	AM PM			
		PM	AM PM			
		PM	AM PM			
	Total Hours for Week 1 →			18	Must not be over 40	
Week 2	05/14/2011	AM 10:00 PM	AM 12:00 PM	2	99509	Laundry, cleaned apartment.
	05/15/2011	AM 12:00 PM	AM 3:00 PM	3	99509	Teach Pauline how to use computer.
	05/16/2011	AM 2:00 PM	AM 8:00 PM	6	99509	Worked with Pauline on practicing better safety skills at home.
	05/17/2011	AM 8:00 PM	AM 4:00 PM	8	99509	Worked with Pauline on washing dishes and cleaning the apartment.
	05/18/2011	AM 8:00 PM	AM 1:00 PM	5	99509	Prepared frozen meals for next week.
		AM PM	AM PM			
		AM PM	AM PM			
		AM PM	AM PM			
		AM PM	AM PM			
	Total Hours for Week 2 →			24	Must not be over 40	
	Total Hours for Timesheet (2 weeks)			42	Must not be over 80	

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

Split Shift
8AM – 11AM Homemaker/Direct Support Services
2PM – 8PM Community Direct Support/Navigation

Total Hours for Week 1 + Week 2

Ellie Employee 5/21/2011
Employee Signature **Date**
Ellie Employee
Employee Printed Name

Pauline Participant 5/21/11
Employer Signature **Date**
Pauline Participant
Employer Printed Name

Signed & dated on or after last service date

10. Dental Services

10.1. Dental Services Information

10.1.1. Dental services are defined as those diagnostic, preventive or corrective procedures to the teeth and associated structures of the oral cavity furnished by, or under the supervision of, a dentist that affect the oral or general health of a Medicaid eligible recipient. See 42 CFR Section 440.100(a).

10.1.2. Definitions

10.1.2.1. Reserved

10.1.3. Medical Assistance Division (MAD) also covers dental services, dentures and special services for an eligible recipient who qualifies for services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. See 42 CFR Section 441.55.

10.2. Orthodontics

10.2.1. Eligible Recipient: Under age 21

10.2.2. Eligible Provider:

10.2.2.1. Provider Type: 421- Dentist

10.2.2.2. Taxonomy: 122300000X – Dentist

10.2.3. Provider Requirements:

10.2.3.1 Required Documentation: Completed orthodontic records and treatment plan. The treatment plan must include the diagnosis, the length, and type of treatment, documentation of a favorable prognosis, and a high probability of compliance in completing the treatment program. The treatment plan must document if an orthognathic surgery is planned. Orthodontic records must include:

1. Diagnostic casts or digital study models
2. Full mouth or panoramic x-ray
3. Cephalometric film
4. Diagnostic photographs

5. A completed orthodontic screening form that states the Handicapping Labio-Lingual Deviation Index (HLD) score and indicates the handicapping malocclusion. The provider may submit either the original or a copy

10.2.3.2. Anecdotal information is insufficient to document the presence of a handicapping malocclusion. Statements that are not supported by professional progress notes indicating the patient has difficulty with eating, chewing, or speaking represent anecdotal information. These conditions may be caused by other medical conditions in addition to the misalignment of the teeth.

10.2.4. Medical Necessity Criteria: Orthodontic treatments are interventions indicated for the correction of misalignment of teeth and/or jaws, described as malocclusions, causing a disability in normal oral function. The New Mexico Health Care Authority (HCA) is revising the medical necessity criteria for Handicapping malocclusions for the purpose of determining eligibility under these regulations. Medical necessity shall mean the presence of the following:

10.2.4.1. Auto Qualifiers

1. Cleft palate deformities and other significant craniofacial anomalies.
2. Deep impinging overbite, when the lower incisors are touching the soft tissue. This does not include occasional biting of the cheek.
3. Cross bite of individual anterior teeth in contact with soft tissue or the presence of more than two teeth in crossbite will result in an auto qualifier.
4. Impacted permanent cuspids and/or surgical intervention. This does not include cases where cuspids or incisors will erupt ectopically.
5. Overjet in excess of 7 mm.

10.2.4.2. If none of the above auto qualifier conditions are present, then a minimum score of 26 points or greater is the threshold value on the handicapping labio-lingual deviations (HLD) index for making orthodontic determination of medical necessity. HLD measures the severity of a handicapping malocclusion.

10.2.4.3. If none of the auto qualifier or the minimum score of 26 is met, then the following indicators may be considered in the determination of medical necessity:

1. A medical condition and/or a nutritional deficiency with medical physiological impact, that is documented in the physician progress notes that predate the

diagnosis and request for orthodontics. The condition must be non-responsive to medical treatment without orthodontic treatment.

2. The presence of a speech pathology, that is documented in speech therapy progress notes that predate the diagnosis and request for orthodontics. The condition must be non-responsive to speech therapy without orthodontic treatment.

10.3. Silver Diamine Fluoride (SDF) Provided by Dental Providers

10.3.1. Eligible Recipient: MCOs must allow and reimburse services for members. Requirements and indications must be documented in the member's medical record. Evidence of a comprehensive dental examination by a licensed dental practitioner:

1. For children who are too young to receive conventional restorative treatment in a dental chair.
2. For members who are unable to undergo conventional dental treatment.
3. For older adults who have limited access to dental facilities
4. For people with special needs who are unable to cooperate with dental treatment.

10.3.2. Eligible Provider: Dental service providers must be enrolled as New Mexico Medicaid providers with at least one of the following provider types and specialty codes:

10.3.2.1 Provider Type:

1. 421- Dentist
2. 422- Dental Clinic, Rural Health
3. 423- Dental Hygienist
4. 313/192- Federally Qualified Health Center (FQHC)/Medical and Dental

10.3.3. Provider Requirements:

10.3.3.1 Dental service providers must ensure a comprehensive dental examination by a licensed dental practitioner with consent to treat prior to the application of medicament and indication of tooth number of tooth/teeth treated.

10.3.4. Prior Authorization: A prior authorization is not required for this service

10.3.5. Criteria for application of SDF: The code D1354 allows for compensation to a medical service provider who is treating persons with a conservative treatment of an active, non-

symptomatic carious lesion with no pulpal exposure by topical application of a high caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure, example: xerostomia, severe early childhood caries.

1. Maximum of 2 treatments per tooth per 12-month period.
2. May use on up to 5 teeth per session on one claim.
3. Maximum of 4 treatments per tooth in a lifetime.

10.4. Silver Diamine Fluoride (SDF) Provided by a Physician or Other Qualified Health Care Professional

10.4.1 Eligible Recipient: MCOs must allow and reimburse services for members with the following requirements. Requirements and indications must be documented in the member's medical record. With clinical evidence of caries assessed by a physician, certified nurse practitioner or physician assistant:

1. For children who are too young to receive conventional restorative treatment in a dental chair
2. For members of any age who are unable to undergo conventional dental treatment.
3. For older adults who have limited access to dental facilities
4. For people with special needs who are unable to cooperate with dental treatment.

10.4.2. Provider Requirements: New Mexico medical assistance division (MAD) pays for medically necessary health care services furnished by a New Mexico Medicaid enrolled provider. [NMAC 8.310.3]. Eligible providers are physicians or other qualified health care professionals [Certified Nurse Practitioners (CNP), Certified Nurse Specialist (CNS) & Physician Assistants (PA)].

10.4.3. Prior Authorization: A prior authorization is not required for this service

10.4.4. Criteria for application of SDF: The code 0792T allows for compensation to a medical service provider who is treating persons with a conservative treatment of an active, non-symptomatic carious lesion with no pulpal exposure by topical application of a high caries arresting or inhibiting medicament and without mechanical removal of sound tooth structure, example: xerostomia, severe early childhood caries.

1. Maximum of 2 treatments per tooth per 12-month period.

2. May use on up to 5 teeth per session with only one bill.
3. Maximum of 4 treatments per tooth in a lifetime.

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 HCA 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 lifestyle 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, or firearms.

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.

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 Turquoise 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 preventive services.

The MCO must submit marketing, outreach, retention activities and materials to HCA for review and prior approval. In addition, the MCO must provide HCA 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.

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 HCA's, Communication and Education Bureau's Marketing Coordinator and copy the HCA 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 HCA in electronic file media, in the format prescribed by HCA. 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 HCA 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 HCA 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 HCA 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 HCA.
- 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 HCA for approval.

- **HCA Review of MCO Materials**

The MCO shall ensure all materials submitted to HCA for review meet the following criteria:

- 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 HCA 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 HCA/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 HCA for review together, in lieu of separate submissions;
- All approved materials shall be provided in electronic format to the HCA 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 HCA Marketing Committee. If the MCO intends on using such language in any of the materials, the request for approval must include how the message is related to an Outreach goal.

- **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 HCA 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 HCA.

Any items that include the MCO's logo as well as any reference to Turquoise Care or the State Medicaid program must be approved by HCA 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 giveaway 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);
- 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 HCA/MAD logo;
- Inaccurate, misleading, confusing, or negative information about HCA, 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.

HCA 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.

Subcontractors may only advertise the services they provide and may not make any reference to HCA/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 HCA Marketing Review Committee will review the "Moratorium" status on an annual basis, or at HCA'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
  - HCA/MAD Medicaid Managed Care Services Agreement

12. RESERVED

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 HCA Medicaid eligibility notice. The eligibility notice also directs ABP recipients to the HCA/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.

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.

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 HCA/MAD to include the condition. The HCA/MAD Medical Director will review the request to determine whether the individual's condition should be added.

13.4. Appendices

13.4.1 ABP Benefit Chart

13.4.2 Alternative Benefit Plan-Exempt Medically Frail ConditionsList

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

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 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;
- 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;
- 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 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.

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.

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
Bariatric surgery	Limited to 1 per lifetime. 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 lifetime limit. Criteria may be applied that considers previous attempts by the recipient to lose weight, BMI, health status, etc.
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 “legend” drug).	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.
Hearing aids	Not covered. Hearing screening is covered, but only when part of a routine health exam. Typically; additional separate payment is not made for this part of the exam. Hearing testing by an audiologist or a hearing aid dealer is not a benefit.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program.
HH services	Limited to 100 visits annually – a visit cannot exceed 4 hours. An MCO has the option of providing these services through private duty nursing and nursing registry personnel	Covered under EPSDT without the limitation on the dollar amount or length of visits.

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
Medical foods for errors of inborn metabolism, or as a substitute for other food for weight gain, weight loss, or specialized diets, for use at home by a recipient.	Not covered.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.
Disposable medical supplies such as diapers, under pads, gauzes, gloves, dressings, colostomy supplies, for use at home by a recipient.	Not covered. Except for diabetic supplies (reagents, test strips, needles, test tapes, alcohol swabs, etc.). However, supplies necessary to utilize oxygen or DME such as administer oxygen, use nebulizer, clean tracheas for ventilator use, or assist in treatments such as casts or splints are covered. Medical supplies used on an inpatient basis, applied as part of a treatment in a practitioner's office, outpatient hospital, residential facilities, as a HH service, etc. are covered though often these items are not paid separately in addition to the payment for the overall service. When separate payment is allowed in these settings, the items are considered covered.	Covered using the same provisions as for children under EPSDT in the standard Medicaid program. May be subjected to criteria that assure medical necessity.
Pulmonary rehabilitation	Limited to 36 hours per year.	Covered under EPSDT without the limitation on the number of visits.
Rehabilitation and Habilitation • PT • OT • SLP	Rehabilitative services for short-term physical, occupational, and speech therapies are covered. Short-term therapy includes therapy services that produce significant and demonstrable improvement within a two-month period from the initial date of treatment. Extension of short-term therapy beyond the initial two months may be extended for one period of up to two months, dependent on the approval of the MCO'S medical director, only if such services can be expected to result in continued significant improvement of the Member's physical condition within the extension period. Other than the above onetime extension, therapy services extending beyond the two-month period from the initial date of treatment are considered long-term therapy and are not covered.	Covered under EPSDT without the limitation on duration.

Service	Limitations for ABP Recipients (COE 100) for Ages 21 and above	For Ages 19 and 20 Limitations do not apply to ABP recipients (COE 100) who are Ages 19 or 20 because of EPSDT rules. Recipients Under Age 19 Are Not
Extended care hospitals (LTC hospitals)	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). 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.	Covered under EPSDT without the limitations.
Sleep studies	Not covered.	Covered under EPSDT.
Transplants	Limited to 2 per lifetime.	Covered under EPSDT without the dollar amount limitation.

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	There are no age or dollar limits for Applied Behavioral Analysis (ABA) benefits.
Disease management	
Electroconvulsive therapy	
Educational materials and counseling for a healthy lifestyle	
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.

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.
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.

Service	USPSTF Recommendations	Application to Medicaid
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.
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.

Service	USPSTF Recommendations	Application to Medicaid
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.
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.

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
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.

Service	USPSTF Recommendations	Application to Medicaid
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.

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
- 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
- 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 (Periarteritis Nodosa)
- Polycystic kidney
- Posterolateral Sclerosis
- Renal failure
- Serious Mental Illness – refer to the Serious Mental Illness (SMI) Criteria Checklist effective July 27, 2010 (or subsequent replacement version)
- Sickle Cell Anemia

- Silicosis
- Splenic Anemia (True Banti's Syndrome)
- Still's Disease
- Stroke (CVA)
- Syringomyelia
- Tabes Dorsalis (Locomotor Ataxia)
- Terminal illness requiring hospice care
- Thalassemia (Cooley's or Mediterranean Anemia)
- Topectomy and Lobotomy
- Wilson's Disease

13.4.3. Chronic SUD Criteria

SUD Criteria	DSM-V ICD-9	DSM-V ICD-10	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. HCA (formerly HSD) March 2016.

13.4.4. SMI Criteria Checklist/SED 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.

□ 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.



Severe Emotional Disturbance (SED) determination is based on the age of the individual, diagnoses, functional impairment or symptoms, and duration of the disorder. The child/adolescent must meet all of the following criteria:

☐ 1. **Age:**

☐ be a person under the age of 18;

OR

☐ be a person between the ages of 18 and 21, who received services prior to the 18th birthday, was diagnosed with a SED, and demonstrates a continued need for services.

☐ 2. **Diagnoses:**

Must meet A *or* B.

☐ A. The child/adolescent has an emotional and/or behavioral disability that has been diagnosed through the classification system in the current *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders*.

- Diagnoses codes and descriptions that are found in Appendix A and Appendix B of this document are those providing a primary reason for receiving public system behavioral health services.

☐ B. The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the

simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. [*Dear State Director letter,* July 11, 2013, from CMS, SAMHSA, ACF.] In order to qualify as a complex trauma diagnosis the child must have experienced one of the following traumatic events:

- ☐ Abandoned or neglected;
- ☐ Sexually abused;
- ☐ Sexually exploited;
- ☐ Physically abused;
- ☐ Emotionally abused; or
- ☐ Repeated exposure to domestic violence.

In addition to one of the qualifying traumatic events above, there must also be an ex parte order issued by the children's court or the district court which includes a sworn written statement of facts showing probable cause exists to believe that the child is abused or neglected and that custody is necessary.

☐ 3. **Functional Impairment:**

The child/adolescent must have a Functional Impairment in two of the listed capacities:

☐ *Functioning in self-care:*

Impairment in self-care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes, and meeting of nutritional needs.

☐ *Functioning in community:*

Inability to maintain safety without assistance; a consistent lack of age- appropriate behavioral controls, decision-making, judgment and value systems which result in potential out-of-home placement.

☐ *Functioning in social relationships:*

Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults. Children and adolescents exhibit constrictions in their capacities for shared attention, engagement, initiation of two-way effective communication, and shared social problem solving.

☐ *Functioning in the family:*

Impairment in family function is manifested by a pattern of significantly disruptive behavior exemplified

by repeated and/or unprovoked violence to siblings and/or parents and/or caretakers (e.g., foster parents), disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, in- ability to conform to reasonable expectations that may result in removal from the family or its equivalent). Child-caregiver and family characteristics do not include developmentally based adaptive patterns that support social-emotional well- being. For early childhood functioning, major impairments undermine the fundamental foundation of healthy functioning exhibited by:

- rarely or minimally seeking comfort in distress
- limited positive affect and excessive levels of irritability, sadness or fear
- disruptions in feeding and sleeping patterns
- failure, even in unfamiliar settings, to check back with adult caregivers after venturing away
- willingness to go off with an unfamiliar adult with minimal or no hesitation
- regression of previously learned skills

☐ *Functioning at school/work:*

Impairment in school/work function is manifested by an inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); identification by an IEP team as having an Emotional/Behavioral Disability; or inability to be consistently employed at a self- sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).

☐ 4. **Symptoms:**

Symptoms in one of the following groups:

☐ *Psychotic symptoms:*

Symptoms are characterized by defective or lost contact with reality, often with hallucinations or delusions.

☐ *Danger to self, others and property as a result of emotional disturbance:*

The individual is self-destructive, e.g., at risk for suicide, and/or at risk for causing injury to self, other persons, or significant damage to property.

☐ *Mood and anxiety symptoms*

The disturbance is excessive and causes clinically significant distress and which substantially interferes with or limits the child's role or functioning in family, school, or community activities

☐ *Trauma symptoms:*

Children experiencing or witnessing serious unexpected events that threaten them or others. Children and adolescents who have been exposed to a known single event or series of discrete events experience
a disruption in their age-expected range of emotional and social developmental capacities. Such children may experience:

- a disruption in a number of basic capacities such a sleep, eating, elimination, attention, impulse control, and mood patterns
- under-responsivity to sensations and become sensory seeking, physically very active, aggressive and/or antisocial
- under-responsivity to sensations but not sensory seeking and may shut down further and become lethargic or depressed and difficult to arouse
- over-responsivity to sensations and become hyper-vigilant or demonstrate fear and panic from being overwhelmed
- episodes of recurrent flashbacks or dissociation that present as staring or freezing

☐ 5. **Duration:**

☐ The disability must be expected to persist for six months or longer.

Approved by the Behavioral Health Collaborative – August 2015

13.4.5. SMI-SED Criteria

SMI-SED Category	DSM-V ICD-9	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.
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

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
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
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

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
Anxiety Disorders	300.09	F43.9	Other Specified Anxiety Disorder
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
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)

SMI-SED Category	DSM-V ICD-9	DSM-V ICD-10	Description
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
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.

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 HCA/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 the New Mexico Department of Health's Office of School and Adolescent Health (DOH/OSAH) and HCA/MAD certify that SBHCs meet State quality standards. HCA/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.
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 HCA/MAD Certification for Medicaid billing as either a Provider Type 321 (SBHC) or Provider Type 313 (FQHC):

- Provider Type 313 – FQHC:
  - An FQHC that meets the definition of a SBHC according to Social Security Act Section 2110 (c) (9) and is certified by CMS as a FQHC, meets State requirements of an eligible SBHC 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:
  - This type of SBHC must 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 HCA/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 onsite review conducted by DOH/OSAH.
    If a SBHC sponsored by an FQHC is enrolled as a different provider type than an FQHC, the MCO shall reimburse according to the SBHC provider type.

SBHC Liaison: By January 1st of each year the MCO will provide an update to HCA with the name of their designated SBHC Liaison. The SBHC Liaison is the primary contact and will ensure the following:

- Participate in quarterly MCO SBHC Advisory Committee meetings;
- Conduct SBHC recertification site reviews for medically sponsored SBHCs;
- Receive, facilitate, respond and/or provide referrals to subject matter experts within the MCO for SBHC education, inquiries and general communications with SBHC stakeholders; and
- Collaborate with HCA/MAD, DOH/OSAH, contractors, SBHC Sponsors and Site Coordinators.

DOH/OSAH and HCA/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.

14.2. Initial Certification Process

SBHCs and sponsoring entities interested in becoming certified for the first time must contact DOH/OSAH to begin the contracting process. To complete an initial onsite review and receive a MAD Provider Medicaid Eligibility Letter DOH/OSAH will provide interested parties with the following:

- Standards and Benchmarks;
- SBHC Site Review Self-assessment; and
- Technical assistance as needed

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.

- Initial On-Site Review:
  - DOH/OSAH will conduct an initial on-site review with the SBHC staff and sponsor to include discussion of findings, questions, concerns, and recommendations;
    - DOH/OSAH will provide HCA/MAD with documentation of the initial on-site review
  - HCA/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 HCA/MAD letter will include the effective date the SBHC and Sponsor are eligible to begin billing Medicaid; and
    - If the SBHC/Sponsor failed, the HCA/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, HCA/MAD will send notification to the SBHC/Sponsor requesting a corrective action plan (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 HCA/MAD before or on the 60th calendar day;
      - HCA/MAD will determine what documentation and in what format is required based on the CAP and resolution of deficiencies;

- HCA/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, HCA/MAD will collaborate with DOH/OSAH to determine if certification/recertification is possible and next steps.

- Turquoise Care Enrollment:
  - SBHCs must obtain an individual NPI from CMS.
  - SBHCs must submit a MAD 335 application to Conduent as either provider type 313 or provider type 321:
    - SBHCs with Provider Type 313 must submit a copy of documentation from CMS certifying the center as an FQHC; and
    - SBHCs with Provider Type 321 must submit a copy of the MAD Medicaid Eligibility Letter.
  - Upon completion of the successful enrollment with HCA/MAD, SBHCs will finalize agreements with MCOs:
    - SBHCs will also affiliate every rendering provider with the SBHC in the New Mexico Medicaid System;
    - 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.

14.3. Recertification Process

The HCA/MAD letter of New Mexico Medicaid Eligibility is issued for a period of three years and is subject to revocation in the event that HCA/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.

- Provider Type 321s with Non-Medical Sponsorship Recertification Process review will be conducted by the DOH/OSAH 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 DOH/OSAH site review will be conducted as outlined in Certification Process above.

- The recertification process for Medically Sponsored SBHCs contracted with DOH/OSAH is the responsibility of the MCOs.
  - In January of each year, no later than the first quarterly meeting of the MCO SBHC Advisory Committee, HCAMAD 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 on-site review.
  - The MCO will schedule the on-site review with the Medical Sponsor for no later than six weeks before the expiration of current certification.
  - The review may be conducted remotely for additional SBHC sites. There is no requirement for an on-site visit for every individual SBHC under the same sponsoring entity.
  - **In preparation of the on-site review the MCO shall:**
    - Within one month of the site review 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.
    - Instruct the Medical Sponsor and SBHC to prepare to make available hard or electronic copies of:
      - Attestation Statement for Federally Qualified Health Centers (Exhibit 177) or copy of Acknowledgment of Ability to Comply with New Mexico Standards and Benchmarks for School-based Health Centers.
      - Facility Documentation:
        - Facility licenses,
        - Evidence of other licensure and/or certification by appropriate jurisdictional agencies as requested;
        - The latest fire inspection report by the fire authority with jurisdiction over the site;
        - Valid license from the New Mexico Board of Pharmacy;

- Current Clinical Laboratory Improvement Amendments (CLIA) certificate;
- Evidence of compliance with such standards such as the requirement for "No Smoking" signs, "Handicap Accessibility" signs, and the posting of appropriate licenses

- SBHC Policy and Procedure Manual, including the policies and procedures described in the Standards and Benchmarks;
- Complaint logs, Material Safety Data Sheets (MSDS), pharmacy logs, and laboratory logs;
- Access to Medical Records;
- Other materials that may be specified by the Site Review Team;
- Staff Documentation:
  - Current license, registration or certificate of each staff Member for which a license, registration, or certification is required by the State of New Mexico;
  - Health training certificates and logs of all staff;
- Completed SBHC Site Review Self-Assessment for every SBHC;
  - Review the completed SBHC Site Review Self-Assessment for completeness and discrepancies;
  - MCO's should reschedule the onsite review if SBHC Site Review Self-Assessment is not provided 1 week prior or is incomplete;

- **Recertification Onsite Review shall:**
  - Meet with the clinic staff and sponsor representatives in person, to discuss the site review process;
  - Conduct a visual review and use the HCA/MAD Electronic Assessment Tool to determine adherence to the SBHC Standards and Benchmarks;
  - Medical Record Review of the designated MCOs members shall be conducted per the HCA/MAD training guidelines; and
  - Conduct an exit interview with the staff and sponsor to discuss findings, questions, concerns, and recommendations. Sponsor will sign the Electronic Assessment Tool Summary and a verbal indication will be given of the certification status.

- **After Onsite Review Activities:**
  - The MCO will deliver the site review documentation to HCA/MAD within 10 business days. This documentation includes:
    - All SBHC Site Review Self-Assessment(s)
    - Electronic Assessment Tool- Scoring
    - Electronic Assessment Tool- Summary
  - HCA/MAD will compile the data and make the final determination for recertification. HCA final determination will be demonstrated by the MAD Medicaid Eligibility Letter. This letter will be distributed by HCA/MAD directly to the Sponsoring Entity and MCOs.
  - If the SBHC/Sponsor failed, HCA/MAD will follow the CAP process as outlined in the initial certification section.

14.4. Adolescent Confidential Services and Suppression of Explanation of Benefits (EOBs)

SBHC services are subject to Federal and New Mexico state 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 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."

MCO contracts require the MCOs to adopt and implement written confidentiality policies and procedures that conform to state and Federal laws and regulations that:

- Preserve adolescent members' confidentiality rights; and
- Honor adolescent members' rights to receive confidential services under HIPAA and other State and Federal confidentiality provisions.

MCOs are required to adopt and implement policies and procedures unique to SBHCs beyond State and Federal laws and regulations that:

- Suspend the distribution of EOBs and any other communication, written or electronic, to the guardian for all confidential services provided at SBHCs. This would include lab and test results, patient satisfaction surveys, patient portal records, and any other communication that would result in a breach of confidentiality related to adolescent confidential services.

15. Indian Health Service, Tribal Health Providers, and Urban Indian Providers (I/T/U)

Tribal Self Insurance Plan Exception

The rule with Purchase and Referred Care (PRC) under the IHS Policy and Procedures is as follows.

Exception to the IHS Payor of Last Resort – Tribal Self-Insurance Plans. For purposes of IHS administered PRC programs, the Agency will not consider Tribally funded self-insured health plans to be alternate resources for purposes of the IHS's Payor of Last Resort Rule. IHS will assume that a Tribe does not wish for its self-insured plan to be an alternate resource for purposes of PRC and IHS will treat the plan accordingly, once IHS receives documentation to show that the plan is tribal self-insurance. IHS will only treat the Tribe's plan as an alternate resource for purposes of PRC if either of the following occurs:

1. IHS has not received documentation to show that the plan is tribal self-insurance, or
2. IHS receives a tribal resolution from the Tribe's governing body, which clearly states that the Tribe would like IHS to treat the self-insured plan as an alternate resource for purposes of PRC.

REMINDER: This process applies to IHS operated PRC programs. Tribes and Tribal organizations operating PRC programs may choose to follow this coordination process, or they may adopt a different process for addressing this issue.

To the extent any Tribal self-insurance plan has reinsurance or stop loss insurance from which claims are paid by entities other than the Tribe or Tribal organizations, such reinsurance or stop loss insurance shall not be considered Tribal self-insurance; provided that the fact that a Tribal self-insurance plan has reinsurance or stop loss insurance does not mean that the Tribal self-insurance shall be considered an alternate resource.

An exception to the IHS Payor of Last Resort Rule: TRIBAL SELF-INSURANCE PLANS

- The IHS is prohibited from seeking recovery when the health services provided to an eligible patient are covered by a self-insurance health plan funded by a Tribe or Trial organization under Section 206 (f) of the Indian Health Care Improvement Act (IHCIA), P.L. 94-437, 25 U.S.C. § 1621e(f). Consistent with congressional intent not to burden Tribal resources, the Agency has made a determination that tribally-funded self-insured health plans are not to be considered alternate resources for purposes of the IHS Payor of Last Resort Rule.

15.1. FQHC/Tribal 638 Claims Processing

MCOs must configure their systems to pay claims either off the COBA (Coordination of Benefits Agreement) file or paper claims and pay up to the Medicare Office of Management and Budget (OMB) all-inclusive rates (AIR) encounter rates for the applicable year.

For I 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 coinsurance 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 Service and Tribal 638 facilities for the full coinsurance 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. Service locations outside Tribal 638 facilities may include locations such as NFs, schools, teen and wellness centers, chapter houses, homes, and non-IIHS/Tribal 638 hospitals.

SERVICES OUTSIDE AN FQHC/TRIBAL 638 FOUR WALLS & GRACE PERIOD

SHO Letter #16-002 and CMCS Informational Bulletin 01.15.2021

CMCS Informational Bulletin 09.08.2023: CMS is further extending this grace period for states and Tribal facilities for twelve additional months. This will extend the four walls grace period end date to **February 11, 2025**.

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 increased PCS 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; in the sense that 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 HCA 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.

Grievances

The grievance process should not be confused with the appeal and administrative hearing processes. 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 they are 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 the HCA does have a provider hearing process for some fee-for-service provider issues, the MCO provider appeal process **does not** lead to an HCA administrative hearing before the Office of Fair Hearings.

Member Appeal

The Member MCO appeal process is included in the above rule. The Member MCO appeal process can eventually lead to an HCA administrative hearing before the Office of Fair Hearings.

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, an HCA 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.

16.2. The Member's HCA 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 HCA administrative hearing with the Office of Fair Hearings. Within the HCA, 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 HCA 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 HCA administrative hearing is detailed in this rule.

Once a Member's request for an HCA administrative hearing has been received by the Office of Fair Hearings, 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 the HCA administrative hearing final decision is rendered or the Member requests the termination of continuation of the benefit.

Once a Member notifies the Office of Fair Hearings, the Office of Fair Hearings acknowledges receipt of the request to the Member and notifies the MAD Fair Hearing Unit (FHU) and the MCO in writing of the request within relevant information about the Member, including the Member's self-identified issues. MAD FHU maintains a log of all HCA administrative hearing requests. Once the Office of Fair Hearings assigns an Administrative Law Judge (ALJ), the ALJ will send out a scheduling notice of the HCA administrative hearing date, time and call in number to all parties. Parties to the hearing may include legal counsel or other Authorized Representatives. Unless an accommodation is requested and approved by the ALJ, all HCA administrative hearings are conducted telephonically. The assigned ALJ is responsible for the oversight of the HCA administrative hearing process, including conducting the actual hearing.

The formal rules of evidence and civil procedure do not apply to the HCA 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 HCA 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 her HCA administrative hearing final decision has been rendered. The evidence and testimony entered into the hearing record forms the official HCA record and only information contained within the hearing record can be admitted into evidence in a New Mexico district court appeal; HCA, the Member nor the MCO cannot add to or delete from this hearing record after the close of the actual HCA administrative hearing. The State district court is allowed to set aside the HCA 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.

Summary of Evidence (SOE)

The MCO must provide MAD FHU 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 FHU 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 HCA administrative hearing, the ALJ prepares a summary of facts and his or her recommendation and submits this and the entire hearing record to MAD FHU. The record of the HCA 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 HCA administrative process must be completed within 90 calendar days of the date the Member requested the HCA administrative hearing. The Member and other parties to the hearing are provided with the HCA administrative hearing final decision.

The Member has 30 calendar days to file an appeal of the HCA 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 HCA 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 HCA 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 the HCA 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 HCA's primary goals related to its administrative hearings is to have all MCO's implement procedures that are consistent with NMAC and MAD rules 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, HCA is requesting all MCOs use a standardized HCA SOE form. Each SOE shall contain four separate titled sections. The MCO must provide the information listed on each titled section of the SOE to MAD FHU in a timely manner so it may meet the HCA 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 HCA administrative hearing when a Member is transitioning from one MCO to another.

Each MCO is responsible for its own process while still following the instructions for continuation of benefits for the initial 30 calendar days after transfer; the Member's right to request an MCO appeal, and for a continuation of his or her benefits.

Questions and Answers

- If a Member requests an MCO appeal or an HCA 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 HCA 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 HCA 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 the HCA, 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 HCA administrative hearing takes place after the Member has transferred. This is essential because a final determination must be made to determine if the Member is responsible for payment for services that were "continued" under the relinquishing MCO for the time period the Member was enrolled with the relinquishing MCO.
  - When the relinquishing MCO makes a final decision on the Member's appeal, or when the HCA 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 HCA 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 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.

  - The HCA wants to emphasize the contract provision for the 30 calendar day coverage of the Member's benefit by the receiving MCO is an HCA 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 they 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 they transfer 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?

- 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. 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.

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 “HCA 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 the HCA 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 that 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 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 HCA Administrative Hearing, it is important to 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 HCA MCO contract provisions.

- **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.

- **MCO 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 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 Appeal to a request for an Expedited Appeal.

  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.

- **MCO 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.

- **HCA Administrative Hearing**

The Member may request a HCA 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.

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

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 they do not agree with the final Grievance decision, unless the timeframe for an Appeal 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 they have any questions. Inform the Member how to access toll-free numbers with TTY/TTD and interpreter ability.

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.

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.

☐ 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 they have 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, they have 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 they 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 an MCO Expedited Appeal) and the anticipated date of the Final Appeal Decision.
- ☐ Provide appropriate forms for an Appeal that has the Member identify how they would like to be contacted.

Briefly describe the Appeal process:

- ☐ Tell the Member that they 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 an 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. Inform the Member to use this contact information if they have 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 HCA 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:

- ☐ If the benefit is already being provided, inform the Member that they 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 they request 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 HCA Administrative Hearing.

- ☐ Explain the process to request a continuation of their 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 a HCA 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.

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 HCA 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.

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 an 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.

☐ 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 a HCA Administrative Hearing if the final decision upholds the 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 HCA 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:
  - ☐ A HCA Expedited Administrative Hearing within 30 calendar days of the date of the MCO Member Appeal Final Decision;
  - ☐ A HCA 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 HCA Administrative Hearing will be included in the Appeal Decision Letter if the decision is not in favor of the Member.
- ☐ Inform the Member that he or she may also request for a HCA Administrative Hearing, if the decision on their Appeal is not timely.
- ☐ Inform the Member that he or she may file a request for a HCA Administrative Hearing if the Member requested an Expedited Appeal, but the MCO denies the expedited status. The HCA 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.

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 a HCA Administrative Hearing which will result in the Administrative Hearing process making the final decision on the issue being appealed.

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:

☐ 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 a HCA 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 a HCA 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 a HCA 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.
- ☐ 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 HCA Administrative Hearing process.
- ☐ Inform the Member that they may request a HCA 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 a HCA Expedited Administrative Hearing within 30 calendar days of the date of the Appeal Final Decision letter. The request for a HCA Expedited Administrative Hearing may be made verbally or in writing.
- ☐ Provide the Member with the HCA Fair Hearing Bureau email and mail addresses, fax and phone numbers, HCA toll-free numbers with TTY/TTD and interpreter capability.

- ☐ Inform the Member that if they request a HCA Administrative Hearing, the MCO will not take steps to recoup the cost of the Member's current disputed benefit until the HCA 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 HCA Administrative Hearing process.
- ☐ Inform the Member of the recoupment of the cost of the Member's continued disputed current benefit if the HCA 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.

17. Managed Care Reporting

17.1. General Information

MCOs are required to comply with all reporting requirements established by HCA 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: Turquoise Care MCO Reports.

17.2. General Requirements

HCA, 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, HCA may, at any time, revise existing report content, and HCA may seek MCO input on proposed changes. Once HCA issues finalized Report Instructions and Templates, MCOs will have at least 14 calendar days, and additional time at HCA's discretion, to implement report content changes depending on the nature of the changes.

17.3. MCO Reporting and Intake

HCA'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 15 calendar days from the due date of the report;
- 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 an 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 HCA requirements and performance standards;
- Tracking and monitoring the MCO report review and data analysis process;
- Managing HCA Lead Report Reviewer timeframes; and
- Uploading HCA feedback (Acceptance, Rejection, Final Review Tool, etc.) to the FTP site.

17.4. Report Rejection

An MCO Report may be rejected, by HCA, 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 HCA Contract Manager will determine whether a Rejection is warranted, or if a technical assistance call or other solution is preferred.

17.5. MCO Report Resubmission

HCA has developed and implemented several processes (technical assistance call, self-identified error resubmission [SIER]), and Feedback Error Identification Report form to allow for improvement of the MCOs' data accuracy and reporting compliance.

Technical Assistance Call Process

HCA Contract Managers and SMEs are available to provide technical assistance to MCOs in the following areas:

- Review of HCA 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, HCA may conduct a technical assistance call to address data related questions and concerns. This provides an opportunity for MCOs to gain valuable guidance from HCA Contract Managers and SMEs.

After a technical assistance call is held, the HCA 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 HCA Contract Manager.

MCOs are required to accurately label each subsequent report submission with the appropriate version number (v2, v3, v4).

HCA Contract Managers approve all MCO Report Rejections and SIERs; manage the technical assistance call process; and direct the overall resubmission of MCO reports.

17.6. Report Revisions

HCA 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 HCA'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 HCA. If the request is approved, the Turquoise 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. HCA then issues the final reporting package to MCOs for implementation.

17.7. System Availability Reporting

MCOs must notify HCA 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 HCA in advance via email at HSD.MCOSystemsAvail@hsd.nm.gov in order to obtain approval by HCA. In the event of an unforeseen and unscheduled inaccessibility of any critical systems, MCOs must notify HCA 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 their HCA Contract Manager immediately via email at HCA-MCODeliverables@hca.nm.gov and copy JohnH.Padilla@hca.nm.gov. . MCOs are to provide to HCA, within five business days, documentation that includes a CAP describing how MCO will prevent the problem from occurring again.

In the event of a critical systems unavailability that has been approved by HCA but exceeds the expected and approved downtime , MCOs must notify their HCA Contract Manager immediately via email at HCA-MCODeliverables@hca.nm.gov and copy JohnH.Padilla@hca.nm.gov. During Federal and/or State Holidays and weekends, the same processes 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@hca.nm.gov.

For any email notification pertaining to the above direction, MCOs must use the HCA template included in this Section as 17.8.2: Systems Availability Incident or Event Report.

17.8. Appendices

17.8.1 Turquoise Care MCO Reports

17.8.2 Systems Availability Incident or Event Report

17.8.1. Turquoise Care MCO Reports

Report No.		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**	Quarterly	To capture call center statistics and ensure that callers can access a call center agent in a timely manner.	
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**	Quarterly	To capture data regarding the nursing facility (NF) LOC determination process including timeframes, activities of daily living, and care settings.	

Report No.		Frequency	Report Objective	Comment
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.	
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.**

Report No.		Frequency	Report Objective	Comment
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**	Quarterly	To monitor Member and provider grievances, appeals and fair hearings and to track MCO adherence to contractual timeframes.	
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.	

Report No.		Frequency	Report Objective	Comment
44	**Pharmacy Report**	Quarterly	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**
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**

Report No.		Frequency	Report Objective	Comment
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**
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.	
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**

17.8.3. Systems Availability Incident or Event Report

Systems Availability Incident or Event Report

MCO Name	
Report Date	

Name of System Affected	Critical or Non Critical	Functionality of Affected System	Description of Event	Extent of Data Impact/Data Loss	Event Start Date and Time	Event End Date and Time	Event Duration	Recovery Action(s)	Corrective Action Plan, If Applicable

18. Quality

18.1. Performance Improvement Projects (PIPs)

Performance Improvement Projects must be developed in accordance with 42 C.F.R. § 438.330 as directed in section 4.12 of the Managed Care Services Agreement. The Contractor must apply the following criteria to selecting measurement indicators and establishing performance benchmarks and targets:

- Select standardized, evidence-based measurement indicators.
- Benchmarking and baseline statistics should align with national and regional averages.
- Performance targets should indicate a statistically significant improvement in performance compared to the baseline measurement.

Work plans for all PIPs shall be submitted for review and approval from the EQRO prior to implementation.

18.2. 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 Adult Protective Services (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 HCA 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 a NF LOC.
- The MCO shall be required to provide appropriate training and take corrective action as needed to ensure Contracted Provider compliance with Critical Incident requirements.
        - The MCO shall require its Contract Providers to complete a reassessment of risk and update the CCP to address potential gaps in the Member's care, to mitigate assessed risks and to prevent occurrence of further incidents.

- The MCO shall be required to execute provisions describing how services provided under the terms of the Contracted Provider contract are accessed by Members.
  - The Contracted Provider shall be required to provide at least thirty (30) Calendar days advance notice to the MCO when the Contracted Provider is no longer willing or able to provide services to a Member, including the reason for the decision and to cooperate with the Members care coordinator to facilitate a seamless transition to alternate Contracted Provider.

- The MCO be required to address and respond to new PCS authorizations.
  - The MCO shall be required to verify Contract Providers have sufficient staff to provide services, assure Contract Providers assigned have initiated care and initiate procedures in place when services have not begun within five (5) calendar days.
- The MCOs shall be required to follow a process as defined in Agency Based Community Benefit Section 9: where members who wish to receive fewer PCS hours than initially authorized would discuss and work together with their assigned Care Coordinator to determine if reducing hours is reasonable. If so, the Member will sign a new Community Benefit Member Agreement (CBMA). The request for a reduction in hours should occur after at least 60 calendar days into the approved schedule and after a reassessment of approved PCS hours. It is essential that members willingly agree to and sign the CBMA for the reduced PCS hours, with the MCO maintaining a record of this agreement.
- The MCO shall be required to ensure that training is provided upon a Contracted Provider entering into a contract, upon hire of employees, and upon enrollment in the SDBC.
  - The MCO shall be required to ensure that training be provided at least annually thereafter.
  - The MCO shall be required to ensure the training is mandatory and is included in the contract agreement.

- Critical Incident Reports filed as the result of a Member's death and accepted for investigation by the Office of the Medical Investigator (OMI) shall remain in a pending state within the HCA Critical Incident Reporting Portal until the OMI has issued its findings. The MCO is responsible to update the HCA Critical Incident Reporting Portal with the results from the OMI.

- The MCO shall require all staff and Contracted Providers to document updates regarding initiated action(s) taken for the Member and all follow-up activities related to the intervention(s) implemented as a result of the incident. The information should be entered into the HCA Critical Incident Reporting Portal until the established intervention(s) demonstrate the Member's health, safety and welfare are no longer issues of concern.
    - The follow-up action(s) include but are not limited to:
        - Requiring an investigation or intervention for issues of health and safety;
        - Information related to the Member's health, safety and welfare;
        - Communication with internal or external agencies; and
        - Any changes in the Member's health status, including but not limited to; care coordination visits or care coordination investigations or interventions, and/or reassessment or change in the Member's comprehensive care plan.
- BH critical incidents are defined by the BH Critical Incident Protocol.
    - Critical incidents involving BH services for members with a nonqualifying COE must be reported on the Turquoise Care Behavioral Health Critical Incident form for any known, alleged or suspected events of abuse, neglect, exploitation, injuries of unknown origin, death 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 HCA 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.
- The MCO shall ensure follow up with members (either by the agency or care coordinator) according to their Risk Level, utilizing the following criteria:
    - Risk Level I (Low) – 10 hours or fewer of Personal Care Services (PCS) allocated per week with natural support: monthly diary entries

- Risk Level II (Medium) – 11 – 25 hours of PCS services allocated per week: every other week diary entries
- Risk Level III (High) – 26 or more hours of PCS services allocated: weekly diary entries

- A Risk Level must be assigned to all members when a Critical Incident Report (CIR) is filed. Other factors to consider when assigning a Risk Level are:
  - Member's hospitalization and/or ER visit
  - Member's change in condition
  - Member's chronic conditions
  - Member's living situation (e.g., assisted living, long-term care facility, residential treatment center)
  - Member's imminent risk or threat to self and others due to lack of caregiver supervision
- The MCO must initiate review of all incident reports regarding their members within one (1) Business Day of the report submission. This review shall include, at a minimum:
  - Verifying the member's Category of Eligibility (COE) in the YES-NM Medicaid portal and deleting reports for members who do not have a CIRS reportable COE.
  - Ensuring the accuracy of the member's demographics (name, DOB, and SSN) and diagnoses. If a report is filed with the default SSN of 123-45-6789, the MCO should update the SSN of the member. If a report lists the diagnosis as unknown, the MCO should update the CIR with a list of diagnoses.
  - Verifying whether the narrative supports the documented incident type/subcategory and ensuring the primary and secondary categories follow the correct hierarchy.
  - Determining whether the report is a reportable incident or non-reportable incident based on the narrative or additional information obtained. For example, a visit to an Urgent Care does not require a CIR but an ER visit does. If the report is deemed non-reportable then the report must be deleted by the MCO.
  - Assessing the report to ensure that the date of incident and the date the agency first knew of the incident are aligned.
  - Ensuring the report is complete and contains all necessary information or required language (e.g. PCS schedule, whether member is directed or delegated, and reason Emergency Services were utilized) and verifying aspects of the report as needed.

- Conducting outreach to the member's PCS agency for any needed corrections to the CIR
- Ensuring appropriate Adult Protective Services (APS)/Child Protective Services (CPS) follow-up.
- Determining whether an additional CIR needs to be filed related to the incident, such as a member's death related to an emergency room visit.
- Identifying and processing duplicate CIRs to preserve pertinent information and deleting duplicates from the Critical Incident Reporting System (CIRS): when duplicate incidents are identified, narrative and diary entries from the duplicate CIR are transferred into the CIR filed by the agency and the report filed by the MCO is deleted.
- Notifying the member's care coordinator of the CIR and prompting the care coordinator to follow up directly with the member, per their Risk Level requirements.
- Instructing the care coordinator and/or the agency to document their outreach attempts, which may include communication with neighbors, family, PCP, hospital admissions, or law enforcement as applicable.
- Refer unexplained death CIRs to OMI (Office of Medical Investigator) for investigation.
- Referring all reports of Exploitation with subcategory of Falsification of Timesheets to the MCO's internal fraud investigation unit, documenting the referral in diary notes, and ensuring the alleged fraud question is answered yes.
- Ensuring CIRs are filed in a timely manner or contain documentation regarding why the incident was reported late. Providing continued education to agencies on the importance of timely filing.

- MCOs must process all requests for CIR deletions within two (2) business days. If a diary entry requesting deletion is found in a CIR that has not been deleted within two (2) business days, HCA auditors will deduct points from the MCO's monthly CIR Audit score. This is of particular importance at the end of each quarter, as Critical Incident Report #36 data is pulled directly from the CIRS.
- The MCO must utilize the most recently updated PCS and/or Behavioral Health (BH) training presentations as a resource to ensure that CIRs are reported accurately and according to hierarchy guidelines. The MCO must ensure that PCS and BH agencies are directed to utilize these presentations as a resource as well.

- All follow-up entries in the CIRS must be individualized to the member and include documentation of actions taken as a direct result of the CIR, such as provider appointments, medication changes, and environmental modifications. The MCO must perform ongoing reviews of CIRs to ensure that the appropriate and timely follow-up/diary entries have been completed by the agency and/or MCO care coordinator.
- A CIR remains under review until documentation in the diary entries indicates that the critical incident issue is no longer a concern and the member's health, safety, and well-being are addressed. Once this occurs, the MCO may close the CIR.
- The MCO shall utilize all available resources such as Community Health Workers, providers, and natural supports to locate all members with CIRs who are Difficult to Engage (DTE) or Unable to Reach (UTR). If, after completing the required follow-up attempts according to the member's Risk Level for ninety (90) days, a member is DTE or UTR, the MCO must make and document at least three (3) further reasonable outreach efforts (e.g., attempting to contact the Member on different days at different times of the day, using alternative contact numbers, using community agencies to engage Member) to contact a Member to follow up on the critical incident. After these protocols have been completed, a diary entry must document that the incident is being closed due to the member being DTE or UTR and that the required follow-up has been completed. This follow-up would include reviewing internal records/claims that may indicate that a member was seen by a healthcare provider or facility after the date of incident.
- The MCO's critical incident staff must address the CIRs that have remained Under Review for more than 90 days on a monthly basis, including initiating outreach to agencies and care coordinators to explore feasible options for resolving the incident as needed.
- ~~MCOs must document review by clinician of all CIRs for CISC members. This review may be documented as follows in a Critical Incident Reporting System (CIRS) diary entry:~~
    - ~~For incidents that do not require escalation, document the name and title of the clinician who reviewed the incident, e.g., "Reviewed by Mary Sanchez, RN."~~
    - ~~For incidents that require escalation, document the name and title of the clinican who reviewed the incident and the name and title of the clinician it was esclated to, e.g., "Reviewed by John Doe, RN and escalated to Jane Doe, MD."~~

19. Program Integrity

19.1. General Information

The Turquoise 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.

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 HCA, 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 HCA Program Integrity Report ("Report 56") pursuant to the "Turquoise 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 (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;

- 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 "Turquoise Care Reporting Instructions Program Integrity Report #56".

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 over payment;
- 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. § 1320a7k(d)(l), 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 HCA, OIG, CMS or its contractors, HCA'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 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 "Turquoise 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, HCA, at its sole discretion and related to administrative and civil remedy available to HCA, may seek recovery against the provider for any overpayments and any refund shall be HCA'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.

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 HCA, 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.

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 HCA (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 HCA's requirements set forth in 42 CFR 1002.3(b)(3).

The MCO is required to document and report all adverse actions taken on providers on Report 56 pursuant to the "Turquoise Care Reporting Instructions Program Integrity Report #56".

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.

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 Turquoise 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 nonretaliation policy.

20. Pharmacy

20.1. General Information

Pharmacy Benefits: Turquoise Care Programs

Prescription drugs are a benefit under the Turquoise Care program to be covered by the MCOs. MCOs shall support HCA in promptly responding to public and legislative inquiries involving the design and management of the MCO's pharmacy benefit.

20.2. 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.

MCOs shall comply with all new legislative requirements relating to medication formularies. Starting on July 1, 2026, MCOs shall follow guidance for the Unified Prescription Drug List (UPDL) and corresponding prior authorization (PA) criteria. In addition, the MCOs shall follow the HCAs guidance for reviewing and operationalizing updates of the UPDL.

The MCOs must follow HCA's expectation for timely submission of pharmacy claims data to support PDL development and rebate invoicing.

MCOs shall cover select multi-source generic over-the-counter items as identified by HCA and posted on the HCA website.

MCOs shall not impose step therapy or prior authorization requirements before authorizing coverage for medication approved by the federal food and drug administration that is prescribed for the treatment of an autoimmune disorder, a behavioral health condition, cancer, a substance use disorder, or a rare disease or condition affecting less than 200,000 people in the United States pursuant to a medical necessity determination, except in cases in which a biosimilar, interchangeable biologic or generic version is available.

MCOs shall not require prior authorization for any Medication Assisted Treatment (MAT) medications and shall comply with the following:

- Medication Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. There are FDA approved medications to treat alcohol use disorder, smoking and opioid use disorder.
- MCOs are directed to cease requiring prior authorization for any FDA-approved MAT drugs, including but not limited to methadone, buprenorphine, naltrexone, and buprenorphine/naloxone combinations. New drugs, formulations and delivery routes for these medications are created frequently, and MCOs are directed to ensure that all MAT drugs and all forms of those drugs are available to Medicaid members without unnecessary barriers.
- Generic first policy for MAT drugs defined:
    - An MCO can require a recipient to use a generic version of a drug prescribed as a brand name unless the prescriber specifically states on the prescription “brand medically necessary.” When the “brand medically necessary” is written by hand on the prescription (not a rubber stamp), a pharmacy bills using a “dispense as written” indicator on the National Council for Prescription Drug Programs (NCPDP) transaction. In this case, the MCO must pay for the brand name version; this is a federal requirement. In this case, no step therapy may be required.
- No Prior Authorizations on MAT Drugs
    - No prior authorization is required for any MAT drug in any formulation when used to treat opioid use disorders. Any formulation of buprenorphine FDA approved for the treatment of opioid use disorders is exempt from the generic-first coverage provisions of 8.324.4.12 NMAC. Prescribers should specifically state on the prescription either in writing or electronic indication “brand medically necessary.” The prescriber must maintain in the patient care notes the patient has failed the generic therapy or did not maintain a therapeutic response on the generic equivalent. The pharmacy then bills using the “dispense as written” indicator on the NCPDP claim submission. Best clinical practices when prescribing buprenorphine for the treatment of opioid use disorders (e.g. systematic checking of the prescription monitoring program and periodic urine

drug screening) should be addressed through a provider alert rather than a prior authorization process.

- MCOs must cover all vaccines as indicated on the CDC vaccine schedule.

20.3. 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:

- 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;
- Quarterly data submission concerning number of requests, approvals, and denials for any medications requiring prior approval.
- A comprehensive plan of outreach to the MCOs' referring providers requesting oral drug treatment for chronic HCV infected patients. This is to include patients who have a positive Hepatitis C Ribonucleic Acid (HCV RNA) test within the past two calendar years and have not received treatment.
- 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 Turquoise Care members with chronic HCV infection:

- Access to drug therapy, that does not include a prior authorization or step therapy for glecaprevir/pibrentasivir (Mavyret®) or sofosbuvir /velpatasvir (Epclusa®).
- All members over age 17, all HCV genotypes, with a positive Hepatitis C RNA level;
- The MCOs shall ensure (using the AASLD/IDSA guidelines) that each treatment request is appropriate for any medication requests for the treatment of Hepatitis C other than glecaprevir/pibrentasivir (Mavyret®) or sofosbuvir /velpatasvir (Epclusa®).

- Plans may require resistance associated substitutions testing, based on the American Association for the Study of Liver Disease (AASLD) guidance.

- Guidance regarding lost or stolen medications:
  - MCOs shall use the same criteria currently used for refills of other lost or stolen medications.

- 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.

Human Immunodeficiency Virus

- MCO's must maintain an appropriate formulary for HIV medications. MCO's must cover pre and post exposure prophylactic medications without a prior authorization.
- MCO's must cover all formulations of oral combination medications. MCO's must not mandate the use of individual oral therapies when a combination option is available.
- MCO's must offer a reasonable path for long acting injectable HIV medications to members.

20.4. Medical Aid in Dying

- Medical Aid in Dying (MAID) compounded prescription orders are not to be filled by the MCO's PBM. Any members requesting a MAID compound via appropriate channels are to have the compounded MAID prescription submitted to the FFS PBM.

20.5 Delivery of Necessary Diabetic Resources

MCO's shall comply with 2023 Legislation (HB 53)

- Absent a change in diagnosis or in a covered Member's management of diabetes treatment or its complications, or treatment or diabetes or its complications, the MCO shall not require more than one prior authorization per policy period for any single drug or category of item prescribed as medically necessary by the covered Member's health care prescriber.

- (1) blood glucose monitors, including those for persons with disabilities, including the legally blind;
- (2) test strips for blood glucose monitors;
- (3) visual reading urine and ketone strips;
- (4) lancets and lancet devices;
- (5) insulin;
- (6) injection aids, including those adaptable to meet the needs of persons with disabilities, including the legally blind;
- (7) syringes;
- (8) prescriptive oral agents for controlling blood sugar levels;
- (9) medically necessary podiatric appliances for prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment;
- (10) glucagon emergency kits

• Changes in the prescribed dose of a drug; quantities of supplies needed to administer a prescribed drug; quantities of blood glucose self-testing equipment and supplies; or quantities of supplies needed to use or operate devices for which a covered Member has received prior authorization during the policy year shall not be subject to additional prior authorization requirements in the same policy year if prescribed as medically necessary by the covered Member's health care practitioner. This does not construe required payment for diabetes resources that are not a covered benefit.

20.6. Indian Health Service & Tribal 638 Outpatient Pharmacy Annual All Inclusive Rate (AIR) Reimbursement

MCOs shall follow federal requirements related to reimbursement to MCO contracted Indian Health Service (I.H.S.) and Tribal 638 outpatient pharmacies.

- Each year the MCOs are required to reimburse the AIR published annually by the Federal Register and must continue the rate assigned from the previous year until that new rate is published in the Federal Register. It is the MCO's responsibility to check the Federal Register's

publication for the annual rate posted. All affected dates of service for pharmacy drug claims will be adjusted and reprocessed to reflect the new reimbursement rate annually.

- Pharmacy drug claims reimbursed at the AIR are not eligible for professional dispensing, pharmaceutical administration, and/or compounding fees.
- The AIR for pharmacy drug services may be billed in addition to billing an I.H.S. or Tribal 638 physical health, behavioral health, or dental encounter that is provided on the same day. I.H.S. or Tribal 638 outpatient pharmacies will continue to bill the MCOs pharmacy benefit managers (PBMs). Excluded from this reimbursement change are durable medical equipment, medical supplies, and over the counter orthotic items.
- MCOs are required to have their PBMs update their claims processing systems to allow payment of the AIR on outpatient pharmacy drug claims effective for dates of service since March 1, 2021 or beginning July 1, 2024 of the Turquoise Care contract.
- MCOs are required to have all adjustments completed within 120 days from the time notification is received. MCOs are required to provide 30-, 60-, and 90-day updates on the status of claims adjustment; and confirm within 120-days that all adjustments have been completed. No further updates are required once the final completion notification of claims adjustment has been received.

MCO's must notify HCA when the new annual rate is updated and when all adjustments have been completed.

20.7. 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 payment for the ingredient cost of a drug at a value that is at least equal to the national average drug acquisition cost for the prescription drug at the time that the drug is administered or dispensed, or if data for the National Average Drug Acquisition Cost (NADAC) is unavailable, the Wholesale Acquisition Cost (WAC) of the drug.

The professional dispensing fees (PDFs) paid to community-based pharmacies will mirror the FFS PDF and shall comply with any future FFS PDF changes.

Where there is no NADAC or WAC 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. 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 or WAC price available.

- 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 Turquoise 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;
  - 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. HCA develops and maintains the criteria for inclusion on the list and applies only to community-based pharmacies that participate in the MCOs' Turquoise Care network. Inclusion of a pharmacy on the list does not mandate inclusion of the pharmacy in the MCOs' Turquoise 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' Turquoise 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 HCA/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 including any applicable professional dispensing fees for Community Based Pharmacies, as directed by HCA; and

- MCOs must pay compounding fees when a pharmacist must prepare a compound medication for a covered FDA approved drug/ingredient, for a dosage form or strength not already commercially available, as written in a clinician's prescription. Neither compounding fees nor reimbursement will apply to a compound that includes non-covered pharmacy products as defined by MAD regulations. MCOs must also pay HCA-required administration and incentive fees for pharmacist's prescribing/consultation services, when the pharmacist is enrolled with HCA, permitted by license, and credentialed by the MCO, such as may be done for vaccines, smoking cessation products, combined hormonal and injectable contraceptives, and Naloxone. When specifically established by MAD, MCOs will reimburse for administration fees for injections, including but not limited to injectable vaccines and injectable contraceptives; and MCOs will reimburse for the counseling fee for Naloxone, in all formulations/delivery methods. Other counseling for FDA approved drugs, and products, as required by OBRA 90, is a pharmacist's dispensing responsibility.
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- Updating Prices:
  - NADAC prices (or WAC prices for all drug items including OTC) 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), 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 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.

- Medicaid Managed Care shall require all Health center program award recipients, Health center program look-alikes, Native Hawaiian health centers, Tribal and urban Indian health centers, Ryan White HIV/AIDS Program Grantees, Ryan White HIV/AIDS Program grantees, Children's hospitals, Critical access hospitals, Disproportionate share hospitals, Free standing cancer hospitals, Rural referral centers, Sole community hospitals, Black lung clinics, Comprehensive hemophilia diagnostic treatment centers, Title X family planning clinics, Sexually transmitted disease clinics, Tuberculosis clinics, Pharmacies, Outpatient departments, physicians, regional health centers, family planning organizations, state government and other clinics to bill the Actual Acquisition Cost for drugs purchased under Section 340B of the Public Health Service Act, 42 USC 256b, and dispensed to an MCO eligible recipient at the actual acquisition cost of the provider and indicated on the billing transaction as a 340B drug item using the “UD” or “08” modifier. All claims submitted for pharmaceutical items obtained through the 340B program must be identified.
- Medicaid Managed Care claims shall require the manufacturer assigned NDC identifier, a valid HCPCS or CPT code, a “JW” (indicates waste) or “JZ” (no waste) modifier, and the unit of service for the HCPCS or CPT for informational purposes and does not dictate pricing.
- The Centers for Medicare and Medicaid Services (CMS) mandates that Medicare providers report either the “JG” (drug or biological acquired with 340B drug pricing program discount) or TB (drug or biological acquired with 340B drug pricing program discount, reported for informational purposes) modifiers, and shall be accepted by Medicaid Managed Care; requiring the “UD” modifier to identify 340B drug claims.
- 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 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.

20.8. Pharmaceutical Service Reimbursement Parity

Pharmacist Clinicians (Ph.C.s) shall be reimbursed for clinical services at the same rate that is paid to a licensed physician, physician assistant (PA), or advanced nurse practitioner (NP) for the same service. Prescriptive authority for Ph.C.s is limited to the scope of their collaborative practice protocol. Prescriptive authority for pharmacist with independent prescriptive authority shall be limited to those drugs and services, TB tests, Test to Treat and vaccines delineated within currently approved and future New Mexico Board of Pharmacy written prescriptive authority drug therapy protocols.

MCOs are required to have their PBMs update their claims processing systems to allow for billing and payment via pharmacy POS and the medical benefit based on information provided by the HCA. MCO's may accept CMS-1500 or UB-40 for pharmacist clinical services.

Additionally, pharmacist provided clinical services can generally follow the same methodology utilized for clinical encounters as other medical providers. Akin to other providers, pharmacists can be the rendering and billing provider. Medical claims for pharmacist clinical services will be billed via electronic claims submission in accordance with clinical medical billing procedures. CPT codes for billing of pharmacist clinicians and pharmacists with prescriptive authority are listed on the state's website. All clinical services must be documented within a medical record equivalent to the expectations and requirements of equal clinical services provided by a licensed physician, PA, or NP for the same services. Pharmacist Medication Therapy Management (MTM) billing codes are not to be substituted for more applicable services codes, as supported by clinical documentation.

- Pharmacist providers must enroll and credential with New Mexico Medicaid Fee for Service and Managed Care Medical Plans. MCOs must allow credentialing of pharmacists as providers for New Mexico Managed Care Medicaid Plans in a manner that is consistent with other provider types.
- Medications dispensed or administered are to be billed through normal Point of Sale when in a retail setting. Administration fees for vaccines are to be paid based on contracted rates. Medications administered in a clinic setting shall be billed pursuant to clinic billing procedures.

20.9. 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.

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 HCA 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
- 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

20.10. MCO requirements regarding the Drug Rebate Analysis and Management System (DRAMS) and drug rebate dispute resolution

HCA'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. HCA'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, HCA'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). HCA'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 HCA'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.

HCA'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 HCA'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. HCA'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.

20.11. 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)
- 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 HCA'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, HCA'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 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.

HCA'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), HCA'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 HCA'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.

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 HCA'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 must contact the provider and determine if they really used the NDC code reported.

The provider must adjust and resubmit the claim if the incorrect NDC code was used. All timely filing applies to resubmission of claims.

Communicating with HCA's PBM on Disputes and Correcting Errors

The MCO is to notify HCA's PBM of claims on which the units were incorrect. HCA's PBM will enter a comment into DRAMS that the units were incorrect and that the MCO is working on adjustments. HCA's PBM will notify the manufacture regarding the status of the dispute.

HCA'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 HCA's PBM. HCA'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. HCA's PBM will notify the manufacturer. The manufacturer may request further documentation such as an invoice from the provider. When further documentation is requested, HCA'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 Pharmacy Benefits Manager Regulation Act, NMSA 1978 § 59A-61. A PBM or representative of a PBM may not do any of the following:
    - Engage in spread pricing.
    - Cause or knowingly permit the use of any advertisement, promotion, solicitation, representation, proposal, or offer that is untrue, deceptive, or misleading.

- Unless reviewed and approved by the Superintendent of Insurance Commissioner, charge a pharmacist or pharmacy a fee related to the adjudication of a claim, including a fee for any of the following:
  - The receipt and processing of a pharmacy claim.
  - The development or management of claims processing services in a pharmacy benefits manager network.
  - Participation in a pharmacy benefits manager network.
- Unless reviewed and approved by the Commissioner in coordination with the Board of Pharmacy, require pharmacy accreditation standards or certification requirements inconsistent with, more stringent than, or in addition to requirements of the Board of Pharmacy.
- Pay or reimburse a pharmacy or pharmacist for the ingredient drug product component of pharmacist services no less than the NADAC, or if the NADAC is unavailable, no less than WAC (unless pricing methodology is established for Community Based Pharmacies).
- Make or permit any reduction of payment for pharmacy goods or services by a pharmacy benefits manager or an insurer directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement, including generic effective rates, brand effective rates, direct and indirect remuneration fees, or any other reduction or aggregate reduction of payment.
- After adjudication of a claim for pharmacy goods or services, directly or indirectly retroactively deny or reduce the claim unless 1 or more of the following applies:
  - The original claim was intentionally submitted fraudulently.
  - The original claim payment was incorrect because the pharmacy or pharmacist had already been paid for the pharmacy goods or services.
  - The pharmacy goods or services were not properly rendered by the pharmacy or pharmacist.

The MCOs shall ensure they are monitoring the PBMs' performance on an ongoing basis and the applicable requirements outlined in the Agreement 7.14: Major Subcontractors and Subcontractors are followed.

21. RESERVED FOR EPSDT

22. Medicaid Home Visiting

22.1. MCOs will reimburse Medicaid Home Visiting providers using the designated procedure codes and modifiers as detailed below with no prior authorization required.

22.1.1 PROVIDER ENROLLMENT: Medicaid Home Visiting Providers will enroll as a Provider Type 317 and a Specialty Type 202.

22.1.2 PROCEDURE CODES: Medicaid Home Visiting Providers will bill on the professional claim type using the approved procedure codes and modifiers to identify the Medicaid Home Visiting Model rendering services. Three procedure codes will be used to distinguish between the three service types. For each of the procedure codes, modifiers will be used to identify the Medicaid Home Visiting service model.

Medicaid Home Visiting Billing Codes

Service Code	Nurse Family Partnership	Parents as Teachers	Child First	Family Connects	Healthy Families America	Safe Care Augmented
H1005 Prenatal Home Visit	H1005 U1	H1005 U2	H1005 U3 UA Clinician and Case Coordinator H1005 U3 UB Clinician only H1005 U3 UC Case Coordinator only	H1005 U4	H1005 U5	H1005 U6
S5111 Postpartum Home Visits	S5111 U1	S5111 U2	S5111 U3 UA Clinician and Case Coordinator S5111 U3 UB Clinician only S5111 U3 UC Case Coordinator only	S5111 U4	S5111 U5	S5111 U6
S9445 Infant Home Visits	S9445 U1	S9445 U2	S9445 U3 UA Clinician and Case Coordinator S9445 U3 UB Clinician only	S9445 U4	S9445 U5	S9445 U6

			S9445 U3 UC Case Coordinator only			

22.1.3 SERVICE LIMITATIONS:

- The agency cannot bill both mother and child for a single visit, however an agency may bill for two separate patients for two separate services, one for the pregnant mother and one for the infant.
- Families may be enrolled in and receive services from more than one model. This enrollment may include two models for the same child, or the family enrollment may involve multiple children enrolled in different home visiting models.
- Procedure code S9445 must be billed under the infant
- If the visit is intended to serve more than one child, services may be billed for each participating child and should follow the guidelines of the service model

22.1.4 UTILIZATION CONTROL: Providers may submit claims for Prenatal, postpartum, and infant/child home visits up to age five. Services billed must align with and maintain the fidelity of the Home Visting Model under which services are rendered, and may include the following services:

- Diet and nutritional education
- Stress Management
- Sexually transmitted disease prevention education
- Tobacco use screening and cessation education
- Alcohol and other substance misuse screening and education
- Breastfeeding support and education
- Guidance and education regarding wellness visits to obtain recommended preventive services

- Maternal-infant safety assessment and education
- Counseling regarding postpartum recovery, family planning, and needs of a newborn
- Assistance establishing a primary source of care and a primary care provider
- Parenting skills and confidence-building
- Child developmental screening at major developmental milestones.

22.1.5 Telemedicine

Telemedicine services must meet the following requirements:

- Must include audio AND visual,
- Be delivered on a real-time basis at the originating and distant site,
- No restrictions on services that can be offered via telehealth, and
- If provider resides outside of New Mexico, must be licensed in New Mexico.

	Section 23: Reserved	**Revision Date:** January 31, 2025 **Effective Date:** December 22, 2025

23. RESERVED FOR REPRODUCTIVE HEALTH

24. Children in State Custody (CISC)

The MCO must issue a Member Identification card to the identified resource/foster family or child's caregiver within 7 days of contact with the Member's assigned Children Youth and Families Department (CYFD) Permanency Planning Worker (PPW).

24.1 Comprehensive Well Child Visit (WCV)

The MCO shall utilize available resources such as the Member's assigned care coordinator, the Member's assigned PPW, a community health worker, care worker or tribal liaison to ensure that the WCV is scheduled within 30 days of placement in State custody.

The MCO shall detail the reason for the missed WCV or scheduling after the required 30-day requirement as directed in Report #70 and should include but not limited to the following reason criteria:

- Could not reach PPW
- Run away
- No longer in State Custody
- No Response/Could not reach guardian
- Refused
- Refusal by child over 14 years or older
- Work related issues
- Acute visit
- Lack of provider availability within 30 days
- No show
- Lack of transportation
- Availability of case worker or foster parent
- Other

The MCO and PPW will collaborate with the CISC's caregiver/resource parent when scheduling the WCV to avoid scheduling conflicts, ensure transportation, and address any cultural and language needs.

24.2 Education and Assistance for CISC, Caregivers and Providers

The MCO shall provide education and assistance to CISC and their caregivers to ensure access to timely and quality care. The MCO must document these efforts in the CISC member file and report to HCA as requested and directed in MCO report #70. Education on and assistance with scheduling should include but is not limited to the following:

- The benefits of Care Coordination
- Transportation benefits provided by the MCO
- The importance of having a WCV within 30 days of placement
- Accessing behavioral health services

The MCO shall educate providers on the unique needs of CISC and should utilize available provider resources such as Primary Care Providers (PCPs), School Based Health Centers, Federally Qualified Health Centers, Rural Health Clinics, and Tribal providers to ensure CISC receive timely care, with a focus on the 30-day WCV

The MCO shall train providers on claims submission and reference the following procedure and diagnosis codes to ensure appropriate billing and reimbursement for the CISC 30-day WCV:

Well Child Check Procedure and Diagnosis Codes
These following codes and diagnosis codes combinations are specified by CMS as criteria for CMS-416 EPSDT Participation Report. This direction has the potential to increase member participation rates. Additionally, the diagnosis codes distinguish the visit as a well visit as opposed to a visit for illness, injury or other.

CPT Codes Preventive Service*	**Description**
99381	New Patient under one year
99382	New Patient (ages 1-4 years)
99383	New Patient (ages 5-11 years)
99384	New Patient (ages 12-17 years)
99385	New Patient (ages 18-39 years)
99391	Established patient under one year
99392	Established patient (ages 1-4 years)
99393	Established patient (ages 5-11 years)
99394	Established patient (ages 12-17 years)
99395	Established patient (ages 18-39 years)
99460	Initial hospital or birthing center care for normal newborn infant
99461	Initial care in other than a hospital or birthing center for normal newborn infant
*These CPT codes do not require use of a “Z” code	
CPT Codes: Evaluation and Management Codes **	**Description**
99202-99205	New Patient
99213-99215	Established Patient
** The above CPT codes must be used in conjunction with at least one of the following “Z” diagnosis codes: Z00.00 through Z00.129, Z00.8, Z02.89 and Z76.1 – Z76.2	

24.3 Critical Incident Reporting (CIR)

MCOs shall ensure that a Critical Incident (CI) involving a CISC COE of 066 or 086 is reported in the HCA CI Portal within 24 hours of the incident.

MCOs shall document review by a clinician for all CIRs for CISC members. This review must be initiated within two (2) business days of the report submission and may be documented as follows in the HCA CI Portal diary entry:

- For incidents that do not require escalation, document the title of the clinician who reviewed the incident, e.g., “Reviewed by RN.”
- For incidents that require escalation, document the title of the clinician who reviewed the incident and the title of the clinician it was escalated to, e.g., “Reviewed by RN and escalated to MD.”

If a CISC member is no longer in state custody but remains in a CISC COE of 066 or 086, the MCO must continue to complete all follow-up required by this policy. In addition, the MCO must reach out to the member’s CYFD Title IV-E specialist so they may contact the HCA MAD Eligibility Bureau to correct the member’s COE to reflect a non-CISC Medicaid COE.

All CISC members must be categorized as a Risk Level III (High): weekly diary entries in the HCA CI Portal.

MCOs must ensure the following items are entered into narrative or diary notes in the HCA CI Portal:

- If a member is in an out-of-state facility, note the name of the facility.
- If a member is housed in a CYFD office, please specify the CYFD office.

MCOs must complete monthly in-person visits for CISC members in an out-of-state facility.

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
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
CISC	Children in State Custody
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
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
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
HCA	Healthcare Authority
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 Service, 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
ISP	Individual Service Plan
JAN	Job Accommodation Network
JJS	Juvenile Justice Services
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
MAID	Medical Aid in Dying
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MCO/UR	Managed Care Organization/Utilization Review
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
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
SED	Sever Emotional Disturbance
SDCB	Self-Directed Community Benefit
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
WAC	Wholesaler's Average Cost